Butler Area School District
Asthma Action Plan

School Year ___/___

Must be completed each school Year

Student Name_____ Birth date_____ Grade_____ Room_____

Asthma Severity: □ Mild Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

Asthma Triggers: □ Colds □ Exercise □ Animals □ Dust □ Smoke □ Food □ Weather

□ Other: _____

Please circle all asthma related answers to show child's condition over the last year.

- School days missed: none_____ 1-3 _____ more than 5_____
- Emergency room visits: none_____ 1-3 _____ more than 5_____
- Hospital admissions: none_____ 1-3 _____ more than 3_____
- Student has medication (inhaler/nebulizer) at school? Yes_____ No_____

Early warning signs (check all that apply)

____wheeze _____cough _____chest tightness

____pain in chest _____pain in back _____short of breath

____difficulty breathing _____little energy to play _____other (_____)

Medications

Taken at home	Dose	Route	Frequency
Taken at School	Dose	Route	Frequency

Side Effects: _____

20 minutes before exercise, this medication should be used.

Medication	Dose	Route	Frequency

****Please notify school nurse when your student required medication before school due to asthma symptoms. ****

Asthma physician's name _____phone #_____

I give my permission for the school nurse to use the information provided to share with Butler Area School District personnel and for the nurse to contact my child's asthma physician listed above to discuss my child's condition as needed.

ParentsSignature_____Phone_____Date _____

Work Phone_____Cell Phone/Pager_____