Asthma Action Plan

Student Name_____Class_____

Parent/Guardian Name_____Primary phone #_____2nd #_____

Emergency Contact Name_____Relationship_____phone #_____

Asthma Doctor's Name_____phone#_____

Parent authorizes the exchange of information about this child's asthma between the healthcare provider and the school nurse. ___Yes ___No Parent Signature_____Date_____

TO BE COMPLETED BY DOCTOR OR OTHER HEALTHCARE PROVIDER:

Asthma is: ___Mild Persistent ___Moderate Persistent ___Severe Persistent ___Intermittent

Daily controller medications (usually given at home**)**

NAME	DOSAGE	FREQUENCY
		☐ Before Exercise

If student has cough; mild wheeze; tight chest; or problems sleeping, playing, or working: use quick relief medicine.

Quick Relief Medicines

NAME	DOSAGE	FREQUENCY

If no improvement after 20 min. or worsening symptoms or if student is very short of breath; having a difficult time talking; or skin around neck or ribs is pulling in:

- **Administer rescue medicines**

NAME	DOSAGE	FREQUENCY

- **Call 911**
- **Contact Parent/Guardian**

Known triggers: _√__Tobacco Smoke ____Exercise ____Pollen _____Mold ____Pets _____Temperature change ____Strong odors or fumes ____Other_____

It is my professional opinion that the student ____should _____should not be allowed to carry and use medications by him/herself.

Physician's Signature_____Date_____

Parent/Guardian Signature_____Date_____