NOBLESVILLE SCHOOLS
ENGAGE | INSPIRE | EMPOWER

Asthma Action Plan

Student Name: ______________________________DOB: ________ Teacher/Grade:_______________

1. How long has your child had asthma?____

2. Rate the severity of his/her asthma? (Circle one) (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

3. How many days would you estimate he/she missed school last year due to asthma? ___________

4. What triggers your child's asthma attack? (check all that apply)

____ illness ____emotions ____pollens/molds ____foods
____weather ____exercise ____odors/fumes ____animals
____fatigue other: ____

5. What does your child do at home to relieve wheezing during an asthma attack?

____breathing exercises ____ uses inhaler ____rest/relaxation
____uses nebulizer ____drinks water ____uses oral medication ____other:
____

6. Please list your child's medication(s)

Daily medication(s): ____
Medication(s) for asthma symptoms: ____

7. Please list the medication(s) that you will provide for the nurse to keep in the clinic
Medication(s) ____
Symptoms that would indicate the need for medication(s)_______________________________________
____

8. How many times has your child been treated in the emergency room in the past year for asthma? __

9. How many times has your child been hospitalized in the past year for asthma? _________________

10. Do you know what your child's baseline peak flow rate is? ____ yes ____no Personal best flow rate: ______ red zone: _________

11. If your child suffers a severe asthma attack at school, what plan of action would you prefer school personnel to take? ____

____

Thank you for your time and assistance in assessing your child's needs in school. By signing this form, you authorize permission for this information to be shared with school personnel who would be responsible for your child during the school day. Thanks!

Parent signature: ____ Date: ______________