Place Child's Photo Here

SENECA VALLEY SCHOOL DISTRICT
ASTHMA ACTION PLAN

Student Name:_____ **DOB:**_____ **Grade:**_____ **Homeroom:**_____

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

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

Medications

Daily:

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Emergency/Rescue:

Name:_____ Dose:_____

Name:_____ Dose:_____

Student's ability to use inhaler:

- □ Independent
- □ Nursing staff to instruct/assist
- □ Nursing staff to supervise

Location of Rescue inhaler:

- □ Student will carry on their person (must have permission in writing from private physician)
- □ Student will have in locker/sports bag for afterschool activities
- □ Student will keep in the health office

Physical Education

PE days and times:_____

- □ Needs to use inhaler before PE
- □ Restrict from PE class if _____

Contact Information

Emergency Calls

1. Mother:_____ Home:_____ Work:_____ Cell:_____
2. Father:_____ Home:_____ Work:_____ Cell:_____
3. Emergency Contact:_____ Home/Cell:_____
4. Physician/Clinic for Asthma Management:_____
   Phone#:_____ Fax #:_____

Parent/Guardian Signature:_____ **Date:**_____
(Required)

Physician Signature:_____ **Date:**_____
(Required)

4/2011