



Asthma Action Plan

School _____

School Year _____

Date _____

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade Level: _____

Parents/Guardians: _____

Home Phone: _____ Work Phone (Mother): _____

Cell Phone: _____ Work Phone (Father): _____

Emergency Contact: _____
Name Relationship Phone

Emergency Contact: _____
Name Relationship Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

Parent/Guardian Signature Date

Completed by Physician

Medical History:

Medial Diagnosis	Severity (mild, moderate, severe)	Prognosis

How often do the asthma attacks occur? _____

Has student been treated in the hospital for asthma in the past year? _____

If yes, when? _____

Identify the conditions that usually start this student's Asthma attack:

- _____ Respiratory Infections
- _____ Changes in temperature
- _____ Emotional stress
- _____ Animals
- _____ Food
- _____ Exercise (describe) _____
- _____ Odors (describe) _____
- _____ Allergic reaction (describe) _____
- _____ Chalk dust/dust
- _____ Carpets in the room
- _____ Pollens
- _____ Molds

Indicate signs/symptoms that are usually present in this student's Asthma attack:

Peak Flow Monitoring:

Is a peak flow meter used? _____ Best Peak Flow Number: _____

Monitoring times: _____



Student Name _____

Daily Medications Regimen:

(Please indicate those medications that will need to be taken at school)

Medication Name	Dosage (Amount)	When to Use

Emergency Medications Regimen:

Medication Name	Dosage (Amount)	When to Use

Emergency Services:

Control of School Environment:

(List any environment control measures, pre-medication, and/or dietary restrictions that the student needs to prevent an Asthma attack).

Individual Considerations (Please indicate any physical activity limitations/adaptations, special procedure/procedures and/or impact on school attendance):

For Inhaled Medications:

_____ I have instructed _____ in the proper way to use his/her medications.

NOTE:

For Inhaled Medications:

For a student to be allowed to carry an inhaler at school/school activities, a Henry County Schools’ “Written Authorization for Self-Administration” form must also be signed by the doctor, parent and student. These forms are available at all schools and at some Henry County school websites.

Physician Printed Name

Physician Signature

Date