

For Clinic Office Use Only
 Date: _____ Reviewed By: _____
 Inhaler Expiration: _____

Student's Name: _____

Summer 2025



Asthma Reactive Airway Care Plan

DOB: _____

Grade (2025-2026): _____

List other asthma medications taken at home: _____

History:
<input type="checkbox"/> Asthma
<input type="checkbox"/> Reactive Airway Disease
<input type="checkbox"/> Other

Usual Symptoms:
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Tightness in chest
<input type="checkbox"/> Coughing
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Other:

Triggers:	
<input type="checkbox"/> Exercise	<input type="checkbox"/> Animals
<input type="checkbox"/> Molds/Mildew	<input type="checkbox"/> Chalk
<input type="checkbox"/> Temperature changes	<input type="checkbox"/> Carpets
<input type="checkbox"/> Pollen	<input type="checkbox"/> Respiratory Infections
<input type="checkbox"/> Strong odors or fumes (room deodorizers, perfumes, fragrances)	
<input type="checkbox"/> Food (specify all)	
<input type="checkbox"/> Other:	

If student complains of above symptoms give the following rescue medicine without delay:

Treatment: Please check all that apply and sign below:

Note: If only one inhaler is brought to School, that inhaler will be kept in the clinic.

Student is to carry inhaler with back up inhaler stored in the classroom.

Student is not to carry rescue inhaler.

Name of Inhaler #1: _____ Give: _____ puffs every _____ hours

Name of Inhaler #2: _____ Give: _____ puffs every _____ hours

Notify parent when the first dose of medicine is not effective.

If no improvement after _____ dose(s) of the rescue inhaler, call 911.

Call parents listed below.

Other instructions:

Parent/Guardian (call first)

Name: _____
 Phone: _____

Parent/Guardian (call second)

Name: _____
 Phone: _____

Emergency Contacts (contacted only if unable to reach both parents)

Name: _____
 Phone: _____

Name: _____
 Phone: _____

Parent Signature: _____ Date: _____