SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

ASTHMA ACTION PLAN

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Parent/Guardian's Name: _____ Phone: _____

Provider's Name: _____ Provider's Phone: _____

Provider's Fax Number: _____

According to our records, you have informed the school that your child has a history of asthma. Please complete the information below. This will help school staff know more about how your child reacts to his/her medical condition.

1. How long has your child had asthma?_____
2. Please rate the severity of his/her asthma with 1 being not severe (treatable without an inhaler), and 10 being severe (hospitalized ED visit)
   (Circle) **0 1 2 3 4 5 6 7 8 9 10**
3. What triggers your child's asthma attacks? (Please check any that apply)

   ___ Illness ___ Emotion ___ Medications ___ Food
   ___ Weather ___ Exercise ___ Cigarette or other smoke ___ Chemical odors
   ___ Fatigue

   Allergies: (please list) _____
4. Describe the type of symptoms your child experiences (e.g., wheezing, coughing, or tightness).

   _____

   _____
5. What does your child do at home to relieve wheezing during an asthma attack? (Please check all that apply.)

   ___ Breathing exercises
   ___ Rest/relaxation
   ___ Drink liquids

   Takes medications:
   ___ Inhaler
   ___ Nebulizer
   ___ Oral medications

   Other (please describe)_____
6. Please list ALL medications your child takes for asthma or any other need.

Name of medication	Dose	Frequency

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7. Side effects of medication your child may, or has experienced:

   _____

8. Control of school environment: (List any environmental control measures, pre-medications, and/or restrictions that the student needs to prevent an asthma episode):

   _____

9. Number of times your child has been taken to an emergency facility for an acute attack of asthma in the past 12 months: _____

10. Emergency action is necessary when the student has symptoms such as:

    _____

11. What action do you advise school personnel to take if your child develops acute signs of an asthma attack? _____

You will be notified by either the nurse or designated school personnel when your child has breathing difficulty.

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year.

_____

Parent/Guardian's Signature Date

Office Use Only - Homeroom/Grade _____