School Year: _____

SAYRE SCHOOL
MAKE·YOUR·MARK

ASTHMA HEALTHCARE PLAN

Student's Name: _____ **DOB:** _____ /_____/ _____

Teacher: _____ Grade: _____

Parent/Guardian(1): _____ Cell: _____

Parent/Guardian(2): _____ Cell: _____

Address/Zip Code: _____

Doctor: _____ Phone #: _____ Hospital of Choice: _____

Emergency Contact if unable to reach Parent/Guardian:

Name: _____ *Phone:* _____ *Relation:* _____

1. Date of student's last asthma episode: ___ /___ /___
2. Has student ever been hospitalized for asthma? ☐ **Yes** ☐ **No**
3. What triggers your student's asthma episodes? (Check all boxes that apply)

   ☐ Pollen ☐ Mold ☐ Dust ☐ Feathers ☐ Animal Dander ☐ Perfume

   ☐ Air Pollution ☐ Smoke ☐ Respiratory Infections ☐ Cold Air ☐ Weather Changes

   ☐ Vigorous Exercise ☐ Foods (Specify) _____

   ☐ Other (Specify) _____
4. What are your student's asthma symptoms? (Check all boxes that apply)

   ☐ Coughing ☐ Wheezing ☐ Chest Tightness ☐ Anxiety/Restlessness

   ☐ Difficulty breathing/shortness of breath ☐ Other (Specify) _____
5. List the Medication(s) your student takes for asthma:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____
6. List any other Medication(s) your student takes:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____
7. Location of Medication/Inhaler: _____
8. Additional Comments: _____

REVIEWED BY: _____ *RN* DATE: _____