

To inspire, empower, and prepare our students for their best future.

ASTHMA ACTION PLAN

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Parent/Guardian's Name: _____ Phone: _____

Physician's name: _____ Physician's phone: _____

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 and the best way to protect the health and safety of your child while at school.

1. How long has your child had asthma? _____
2. Please rate the severity of his/her asthma with 1 being not severe and 10 being severe.

(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 Chemical odors
 Fatigue other smoke

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 Takes medications: Inhaler
 Rest/relaxation Nebulizer
 Drink liquids Oral medications

Other (please describe) _____

6. Does the student carry MDI (Meter Dose Inhaler) at school? Yes No
Where: _____ i.e. backpack, clinic, etc.

7. Please list ALL medications your child takes for asthma or for any other need.

Name of medication

Dose

Frequency

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

9. Does your child use a peak flow meter? ____ Yes ____ No

If yes, what is child's current best peak flow? _____

10. Additional information/instructions: _____

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

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

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

14. Have you ever attended an asthma education class? ____ Yes ____ No

Has your child had asthma education? ____ Yes ____ No

15. 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. Thank you for your cooperation and help in providing the best care for your child.

Parent/Guardian's Signature

Date