

Asthma Action Plan

Name of Student: _____ Date of Birth: _____

Grade: _____ PE Restrictions _____

Emergency Information	
Parent(s)/Guardian(s): _____	
Telephone #: Home: _____	Work: _____ Cell: _____ Pager: _____
Physician's Name: _____ Phone: _____	
Emergency Contact (If unable to reach parent(s):	
Name	Phone
1. _____	
2. _____	

- How severe is your child's asthma: please circle
 Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent
 - Does he/she tend to have asthma episodes with upper respiratory infections? Yes No
 - List Allergies/Triggers: _____ Personal Best Peak Flow _____
 - What is your child's peak flow range: Peak Flow necessary to remain at school _____
- Green Zone** _____ to _____ **Yellow Zone** _____ to _____ **Red Zone** _____ to _____

Medication Taken at Home

Medication	Dose	Frequency (Daily or As Needed)	Reason for Taking

MEDICATIONS TO BE GIVEN AT SCHOOL

Medication	Dose/How Often	When to Take (Before gym, for wheeze, cough, etc.)

- Do you feel your child understands his or her asthma and uses prescribed medication appropriately? Yes No
 - ♦ Does your child use a spacer for inhaled medications? Yes No
- *The above plan will be observed by school personnel.
 If your child's condition worsens, 911 will be called and you will be immediately notified.

Parent Signature _____ Date _____

Physicians Signature _____ Date _____