Asthma Action Plan

Student Name___________________________________________________________Class_____________________
Parent/Guardian Name___________________________________________________Primary phone #________________2nd #___________
Emergency Contact Name________________________________________________Relat._________________phone #_____________________.
Asthma Doctor’s Name_________________________________________________phone#_____________________

Parent authorizes the exchange of information about this child’s asthma between the healthcare provider and
the school nurse. ___Yes ___No Parent Signature________________________________Date____________

TO BE COMPLETED BY DOCTOR OR OTHER HEALTHCARE PROVIDER:
Asthma is:     ___Mild Persistent     ___Moderate Persistent      ___Severe Persistent      ___Intermittent

Daily controller medications (usually given at home)

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If student has cough; mild wheeze; tight chest; or problems sleeping, playing, or working: use quick relief
medicine.

Quick Relief Medicines

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If no improvement after 20 min. or worsening symptoms or if student is very short of breath; having a difficult
time talking; or skin around neck or ribs is pulling in:

- Administer rescue medicines

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- Call 911
- Contact Parent/Guardian

Known triggers:   _√__Tobacco Smoke       ____Exercise          ____Pollen       _____Mold           ____Pets
_____Temperature change       ____Strong odors or fumes       ____Other_________________________

It is my professional opinion that the student ____should _____should not be allowed to carry and use
medications by him/herself.

Physician’s Signature_________________________________________________Date________________

Parent/Guardian Signature____________________________________________Date________________