ACTION PLAN FOR A STUDENT WITH ASTHMA

STUDENT:_____DOB:_____ GRADE:_____SCHOOL YEAR_____

PARENT/GUARDIAN_____PHONE (H)_____

(W)_____

(C)_____

PARENT/GUARDIAN_____PHONE (H)_____

(W)_____

(C)_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE:_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE:_____

STUDENT'S HEALTH CARE PROVIDER_____PHONE:_____

PREFERRED HOSPITAL:_____

ASTHMA TRIGGERS (CHECK EACH THAT APPLY TO YOUR CHILD):

___EXERCISE	___FOOD	___POLLEN
___RESPIRATORY INFECTIONS	___STRONG ODORS OR FUMES	___MOLD
___CHANGE IN TEMPERATURE	___CHALK DUST	___STRESS
___ANIMALS	___CARPET	_____OTHER

COMMENTS:_____

LIST ANY ENVIRONMENTAL CONTROL MEASURES, PRE-MEDICATIONS AND/OR DIETARY RESTRICTIONS THAT YOUR CHILD MAY NEED TO PREVENT AN ASTHMA FLARE-UP:

_____

_____

LIST ANY PREVENTATIVE MEDICATIONS TAKEN AT HOME

NAME OF MEDICATION:	DOSAGE:
1._____	_____
2._____	_____
3._____	_____

MEDICATIONS TO BE USED IN SCHOOL

NAME OF MEDICATION:	DOSAGE:	WHEN TO USE:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Parent Signature:_____ **Date**:_____

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