



Asthma Action Plan

School _____

School Year _____

Date _____

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade Level: _____

Parents/Guardians: _____

Home Phone: _____ Work Phone (Mother): _____

Cell Phone: _____ Work Phone (Father): _____

Emergency Contact: _____
Name Relationship Phone

Emergency Contact: _____
Name Relationship Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

Parent/Guardian Signature Date

Completed by Physician

Medical History:

Medial Diagnosis	Severity (mild, moderate, severe)	Prognosis

How often do the asthma attacks occur? _____

Has student been treated in the hospital for asthma in the past year? _____

If yes, when? _____

Identify the conditions that usually start this student's Asthma attack:

- _____ Respiratory Infections
- _____ Changes in temperature
- _____ Emotional stress
- _____ Animals
- _____ Food
- _____ Exercise (describe) _____
- _____ Odors (describe) _____
- _____ Allergic reaction (describe) _____
- _____ Chalk dust/dust
- _____ Carpets in the room
- _____ Pollens
- _____ Molds

Indicate signs/symptoms that are usually present in this student's Asthma attack:

Peak Flow Monitoring:

Is a peak flow meter used? _____ Best Peak Flow Number: _____

Monitoring times: _____



Student Name _____

Daily Medications Regimen:

(Please indicate those medications that will need to be taken at school)

Medication Name	Dosage (Amount)	When to Use

Emergency Medications Regimen:

Medication Name	Dosage (Amount)	When to Use

Emergency Services:

Control of School Environment:

(List any environment control measures, pre-medication, and/or dietary restrictions that the student needs to prevent an Asthma attack).

Individual Considerations (Please indicate any physical activity limitations/adaptations, special procedure/procedures and/or impact on school attendance):

For Inhaled Medications:

_____ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use the medication by his/herself.

_____ It is my professional opinion that _____ should not carry his/her medication by his/herself.

Physician Printed Name

Physician Signature

Date