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: _____ _____ _____ _____ _____

HENRY COUNTY SCHOOLS

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