

Asthma Action Plan

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Capron Poplar Grove Manchester NBUE NBMS NBHS

Student: _____ **Grade / Teacher:** _____

Years since diagnosed with asthma: _____ Hospitalized for asthma since diagnosis: Yes / No

Last Hospitalization for asthma: _____

P.E. Time (if exercise induced): _____

Asthma Triggers:

- *
- *
- *

Does student carry an inhaler? Yes No / **Is inhaler kept in school office?** Yes No

Asthma Medication Taken: **Name:** _____

Dosage: _____ **Frequency:** _____

Signs of asthma emergency:

- *
- *
- *

***These signs indicate need for emergency care**

- **Call 911**
- **Call parents/guardians**
- **Call school nurse**

Emergency Information: Please circle which number should be called first:

Home, Mother Work, Father Work, Other _____

Parents/Guardians Names: _____

Primary Home Phone Number: _____

Mother Work Number: _____ Father Work Number: _____

Other Number: _____

Other Emergency Numbers:

Physician: _____ Phone: _____

Hospital of Choice (if deemed necessary): _____

Additional Notes: _____

Parent/Guardian Signature: _____ Date: _____