Student Asthma Action Plan

Student Information

Name of Student: _____ Date of Birth: _____

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and Times: _____

Emergency Information

Parent(s') or guardian(s') names: _____

Mother/Guardian

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Father

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Physician's Name _____ Phone # _____

In case of emergency, contact:

1. _____
2. _____
3. _____

My child's usual signs of asthma - ie. coughing, difficulty talking, audible wheezes, chest hurting, shortness of breath, neck "feels funny", etc.

_____

_____

_____

My child's known triggers - _____

_____

All Current Medications

Name of Medication	Dosage	Time

Medications To Be Given at School (if any)

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode
(to be completed by physician)

1. _____
2. _____
3. _____
4. _____

Parent's / guardian Signature _____ Date _____

Physician's Signature _____ Date _____