ASTHMA ACTION PLAN

Student Name: _____ Teacher: _____ Grade: _____

1. How long had your child had asthma? _____
2. Rate the severity of his/asthma (circle one)
   (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)
3. How many days would you estimate he/she missed school last year due to asthma? _____
4. What triggers your child's asthma attack? (check all that apply)

   _____illness _____emotions _____medications _____foods
   _____weather _____exercise _____perfume/chemical odors
   _____fatigue _____other:_____

5. What does your child do at home to relieve wheezing during an asthma attack?
   _____breathing exercises _____uses inhaler
   _____rest/relaxation _____uses nebulizer
   _____drinks water _____uses oral medication

6. Please list your child's medication(s):
   daily medication(s):_____

   medication(s) for asthma symptoms:_____
7. Please list any medication(s) that you will provide for the nurse to keep in the clinic.
   medication(s):_____
   symptoms that would indicate need for medication(s):_____
   _____

8. How many times has your child been treated in the emergency room in the last year for asthma? _____
9. How many times has your child been hospitalized in the past year for asthma? _____
10. How often does your child see a doctor for routine evaluations? _____
11. Do you know what your child's baseline peak flow rate is? _____ yes _____ no
12. If your child suffers a severe asthma attack at school, what plan of action would you prefer school personnel to take? _____
    _____
    _____

Thank you for your time and assistance in helping us care for your child and assessing their special needs at school. By signing this form, you authorize permission for this information to be shared with any school personnel who would be responsible for your child during the day. Thank you!

Parent Signature: _____ Date: _____