

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
- weather
- fatigue
- emotions
- exercise
- other: _____
- medications
- perfume/chemical odors
- foods

5. What does your child do at home to relieve wheezing during an asthma attack?

- breathing exercises
- rest/relaxation
- drinks water
- uses inhaler
- uses nebulizer
- 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: _____