



Asthma Action Plan

Name: _____ D.O.B.: _____

Parent/Guardian Name: _____

Mother Emergency Phone: _____ Father Emergency Phone: _____

Primary healthcare provider: _____ Emergency phone: _____

Asthma specialist: _____ Emergency phone: _____

Known triggers for this child's asthma (circle all that apply)

Animals Colds Excitement Exercise Flowers Grass Dust Mold Smoke Strong odors Tree pollen Weather changes Room deodorizers

Foods (specify): _____

Other (specify): _____

Activities for which this child has needed special attention in the past (circle all that apply)

Visiting animals Outdoors on cold or windy days Petting animals Smelling fumes from strong odors like paint or household cleaners

Playing in freshly cut grass Exposure to pesticides Art projects with chalk, glue or fumes Gardening Sitting on carpets Running hard

Other (specify): _____

Personal best reading: _____ Reading to give extra dose of meds.: _____ Reading to get medical help: _____

How often has this child needed urgent care from a doctor for an asthma attack?

In the past 3 months: _____ In the past 12 months: _____

Has this child ever been hospitalized for asthma? _____ (Y/N) If yes, when? _____

Typical signs and symptoms of the child's asthma episodes (circle all that apply)

Breathing faster Difficulty playing, eating, drinking, talking Persistent coughing Gray/blue lips, fingernails Restlessness, agitation

Chest pain/tightness complaints Face red, pale, swollen Wheezing, sucking in chest/neck Dark circles under eyes Fatigue Grunting

In case of an asthma episode, the following steps will be followed:

Have child sit and try to keep calm

Give medication as prescribed, if available

If there is no improvement after 15 minutes, or there is an increase in symptoms, CALL M.D. or 911

____ I will provide the school with the child's rescue inhaler or nebulizer medication and equipment to use with medication.

____ I will **not** provide the school with the child's rescue inhaler or nebulizer medication.

____ **I understand that an asthma episode can be life threatening and could lead to serious illness and/or death without the medication being available to the staff to administer at the onset of the asthma attack.**

____ My child does not have any prescribed medication.

Notify parents/guardians

Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Doctor Name: _____ Phone Number: _____