Asthma Action Plan

School ______________________________

School Year ____________________ **Date** ______________

Student Name: __________________________ Date of Birth: __________
Teacher: ______________________________ Grade Level: __________
Parents/Guardians: ____
Home Phone: _______________ Work Phone (Mother): ______________
Cell Phone: _______________ Work Phone (Father): ______________

Emergency Contact: ____
Name Relationship Phone

Emergency Contact: ____
Name Relationship Phone

Physician: ______________________________ Phone: ______________

I understand that it is my responsibility as the parent/guardian of ______________ to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

______________________________ ______________________
Parent/Guardian Signature Date

Completed by Physician

Medical History:

Medial Diagnosis	Severity (mild, moderate, severe)	Prognosis

How often do the asthma attacks occur? ______________________________
Has student been treated in the hospital for asthma in the past year? ______________
If yes, when? ______________________________

Identify the conditions that usually start this student's Asthma attack:

- ____ Respiratory Infections
- ____ Changes in temperature
- ____ Emotional stress
- ____ Animals
- ____ Food ______________________________
- ____ Exercise (describe) ______________________________
- ____ Odors (describe) ______________________________
- ____ Allergic reaction (describe) ______________________________
- ____ Chalk dust/dust
- ____ Carpets in the room
- ____ Pollens
- ____ Molds

Indicate signs/symptoms that are usually present in this student's Asthma attack:
____
____

Peak Flow Monitoring:
Is a peak flow meter used? ______________ Best Peak Flow Number: ______________

Monitoring times: ________ ________ ________ ________ ________

Student Name ______________________

Daily Medications Regimen:
(Please indicate those medications that will need to be taken at school)

Medication Name	Dosage (Amount)	When to Use

Emergency Medications Regimen:

Medication Name	Dosage (Amount)	When to Use

Emergency Services:

____
____
____
____

Control of School Environment:
(List any environment control measures, pre-medication, and/or dietary restrictions that the student needs to prevent an Asthma attack).

____
____
____
____

Individual Considerations (Please indicate any physical activity limitations/adaptations, special procedure/procedures and/or impact on school attendance):

____
____
____

For Inhaled Medications:

_____ **I have instructed** ______________________ **in the proper way to use his/her medications.**

NOTE:
For Inhaled Medications:
For a student to be allowed to carry an inhaler at school/school activities, a Henry County Schools' "Written Authorization for Self-Administration" form must also be signed by the doctor, parent and student. These forms are available at all schools and at some Henry County school websites.

______________________ ______________________ ______________
Physician Printed Name | Physician Signature | Date