ASTHMA ACTION /MEDICATION PLAN

'OOL DISTRICT

Student's Name_____ Section/Grade_____

School _____School Year _____

Parent/Guardian Name:_____ Parent/Guardian Phone #_____

Emergency Contact:_____ Emergency Phone#_____

Doctor's Name_____ Doctor's Phone#_____

Effective management of a child with asthma during school requires a partnership between the parent, doctor and the school team. In order to meet the specific needs of your child with asthma, please have your Doctor or Health Care provider complete this asthma form.

Type of Asthma _____

Asthma aggravated by: Allergies _____ Exercise _____Weather _____ Other _____

Medication(s): _____
Dosage: _____
Time(s) to be taken: _____
Frequency of additional doses (list): _____
Side Effects or Cautions (list): _____
Allergies_____
Other Medications taken_____

Peak flow reading, (personal best):_____

Instructions RE: How do you want the school to treat an acute episode? (Please be specific)

_____

Restrictions in sports participation & school activities: (list)

_____

_____

Permission to carry inhaler medication on person: Yes_____ No_____

Physician's Name _____Telephone Number _____

Physician's signature _____Date Last Visit:_____

Parent/Guardian's signature_____Date_____

THIS FORM MUST BE UPDATED EVERY SCHOOL YEAR EVEN IF THERE ARE NO CHANGES.

The reverse side of this form must be completed for self-administration of asthma medication/inhalers only.

PPLH 38 2/05