ASTHMA ACTION PLAN

Physician Signature Required

NAME/_____GRADE_____ DATE_____

EMERGENCY CONTACT_____RELATION_____PHONE_____

Severity Classification

❍ Intermittent ❍ Moderate Persistent ❍ Mild Persistent ❍ Severe Persistent

Triggers

❍ Colds ❍ Smoke ❍ Weather ❍ Exercise ❍ Dust ❍ Air Pollution ❍ Animals ❍ Food

❍ Other _____

If triggered by exercise

1. Premedication (how much and when) _____

2. Exercise modifications _____

An asthma emergency may be characterized by a student struggling to breathe, having difficulty talking or being unable to speak, having retractions (skin between ribs sinks in with each breath), or if the lips or nails turn blue or gray.

SHOULD AN ASTHMA EMERGENCY OCCUR, THE FOLLOWING ACTION SHOULD BE ATTEMPTED:

_____

_____

_____

_____

_____

OTHER MEDICATIONS STUDENT IS TAKING:

Name of medication_____Dosage_____

Name of medication_____Dosage_____

Name of medication_____Dosage_____

Parent/Guardian Signature_____

Physician Signature_____

Physician/Healthcare Provider_____**PHONE**_____