

Individualized Student Asthma Action Plan for the 20__ - 20__ School Year

Student Name: _____ DOB: _____ Grade: _____

Allergies: _____ Medications: _____

School: _____ HR Teacher: _____

The following is to be completed by the PHYSICIAN:

CLASSIFICATION OF CONTROL	TRIGGERS
<input type="checkbox"/> Well Controlled <input type="checkbox"/> Not Well Controlled <input type="checkbox"/> Very Poorly Controlled	<input type="checkbox"/> Colds <input type="checkbox"/> smoke <input type="checkbox"/> Tobacco <input type="checkbox"/> Exercise <input type="checkbox"/> Dust <input type="checkbox"/> Pesticides <input type="checkbox"/> Weather <input type="checkbox"/> Air Pollution <input type="checkbox"/> Animals <input type="checkbox"/> Birds <input type="checkbox"/> Mold <input type="checkbox"/> Cleansers <input type="checkbox"/> Perfume/strong odors <input type="checkbox"/> Cockroaches <input type="checkbox"/> Other _____



Is Medication Needed For This Student Prior To Exercise?

15 Minutes before exercise, please give the following:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 1 Cough, Wheezing, Chest Tightness, or Some Problems Breathing

Please give the following & inform parent/guardian:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 2 If Worse (Symptoms Not Improving)

Please give the following & inform parent/guardian if it has been at least _____ since last dose:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 3 Severe Symptoms (Severe Difficulty Breathing ▪ Trouble Walking or Talking Due to Asthma Symptoms ▪ Quick Relief Medicine Has Not Helped ▪ Lips or Fingernails Blue or Gray)

Activate Emergency Plan:

- 1. Call for 911 for an ambulance AND**
- 2. Contact the parent / guardian AND**

*Give the following **Now** if it has been at least _____ since last dose:*

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

Physician Signature	Physician Name	Phone Number	Date
Parent Signature	Parent Name	Phone Number	Date
LCHD RN Signature	LCHD RN Name	Phone Number	Date

IHP