



Asthma Action Plan

You have indicated that your child has Asthma. The purpose of this form is to allow us to manage your child's asthma in the best possible way throughout the school day. Ultimately, care of your child rests with you, so please give us as much information as possible. As conditions change during the year, please contact the school nurse with any changes in medications or routine.

Please note – an Administration of Medication Form is still required to be signed.

Childs Name: _____ Grade: _____

Please describe what triggers your child's asthma: (exercise, allergies, food, etc.) and what symptoms does your child exhibit during an episode? _____

What limitations does your child have during the school day to minimize breathing problems? (i.e. staying indoors during recess, or sitting out from P.E., etc) _____

What medications (if any) does your child take at home for his or her asthma?

What medication/equipment (if any) will you provide for the school to use for your child? Please specify drug name, dose, time of administration, and how often it can be repeated. If the medicine is only as needed, please specify what signals that the child needs it, and how often it can be repeated. _____

Does your child know when to come to the nurse for their medication, and do they know how to use the medication? _____

Parent Signature: _____ Date: _____