Asthma Action Plan

Date________________

Student's Name _________________________________ D.O.B. ________________ Grade _________

Number of hospitalizations for Asthma _____None _____ 1 _____ 2-4 _____ >4

Triggers: ___ Exercise ___ Strong Odors/Fumes ___ Carpets ___Dust/Chalk ___ Food ________ ___Respiratory Infections _______ Animals ___ Pollens ___ Change in Temperature___ Molds ___ Respiratory Infections Other____

DAILY MANAGEMENT

Peak Flow Monitoring ___ NO ___ YES Goal Range: _________ Best Number: _______________

Inhaled Medications/Dosage:	**When to Use**	**Delivery Method**
________________________	___________	___ Nebulizer ___ Inhaler ___ Chamber
________________________	___________	___ Nebulizer ___ Inhaler ___ Chamber

Oral Medications/ Dosage

1.________________________ 2. _____________________ 3. _________________________

Asthma attack symptoms include:____

Steps to Take During an Asthma Episode:
1.________________________2.________________________3.________________________________

Notify parent if: ____

Seek Emergency Medical Care if symptoms do not improve and notify parent.

Emergency Contacts

1. Dr. ____ Phone Number __________________
2. Parent _____________________________________ Phone Number __________________
3. Emergency contact ___________________________ Phone Number __________________
4. Emergency contact ___________________________ Phone Number __________________

I, the parent of ______________________, authorize the release and exchange of medical information between any of my child's health care providers and St.Vincent. I understand that this is for continuity of care purposes and may occur as needed without any prior notification or additional authorization throughout my child's care in the school system.

Parent/ Guardian Signature ______________________________ Date ______________________