



ASTHMA EMERGENCY ACTION PLAN

Student's Last Name Student's First Name MI Sex Date of Birth Grade

In case of asthma attack, please contact: _____ Phone _____

TO BE COMPLETED BY THE PHYSICIAN

Daily management plan (medications, including dosage and times to be given at school)

Does this student have exercise induced asthma? Yes No

Should this child use an inhaler before engaging in physical exercise and if wheezing during physical activity? Yes No

Activity restrictions (please list) _____

Asthma triggers (please list) _____

Allergies to: (please list medication, insect sting, environmental, and product allergies)

WHAT TO DO IN AN ACUTE ASTHMA EPISODE (Note to physician: Please be detailed, school personnel will use this information for directions in an acute situation.)

Please check all that apply

_____ This student is to use an inhaler before engaging in physical activity and/or if wheezing during physical activity.

_____ I have instructed this student in the proper way to use his/her inhaled medications. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that this child should not carry his/her inhaled medications by him/herself.

_____ I have instructed this student in the proper use of a peak flow meter. His/her personal best peak flow is _____.

Physician's Signature _____ Date _____

Parent/Guardian's Signature(s) _____ Date _____