Asthma Action Plan

Place photo here

Date:_____

School Year:_____

Teacher/Grade_____

Student: _____ DOB: _____

Please list any medications taken daily to manage asthma, including nebulizer treatments.

	Name	Dosage	When to Use
1.			
2.			
3.			

Emergency action is necessary when my child has symptoms such as:

1. _____
2. _____

Emergency Asthma Medications:

	Name	Dosage	When to Use
1.			

Can be repeated for severe breathing difficulty _____times _____minutes apart

2. _____

Can be repeated for severe breathing difficulty _____times _____minutes apart

3. _____

Can be repeated for severe breathing difficulty _____times _____minutes apart

Physician's signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

*Teachers will be notified of your child's asthma on a need to know basis