Public Health
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Board of Health
Sidney-Shelby County

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ASTHMA ACTION PLAN

To the Parents/Guardian of: _____ Age: _____ Grade: _____
Teacher: _____

According to our records you have informed the school that your child has asthma. Please complete the information below. This will help school staff members know more about how your child reacts to his/her medical condition and the best way to protect the health and safety of your child while at school.

Return this form to the public health/school nurse to add to your child's confidential health record. The nurse will inform all appropriate school staff members regarding this information.

1. How long has your child had asthma? _____
2. Please rate the severity of his/her asthma with 1 being not severe and 10 being severe.

   (Circle) 0 1 2 3 4 5 6 7 8 9 10
3. What triggers your child's asthma attacks? (Please check any that apply)

   ___ Illness ___ Emotion ___ Medications ___ Food
   ___ Weather ___ Exercise ___ Cigarette or other smoke ___ Chemical odors
   ___ Fatigue

   Allergies: (please list) _____
4. Describe the type of symptoms your child experiences (e.g. wheezing, coughing, or tightness).

   _____

   _____
5. What does your child do at home to relieve wheezing during an asthma attack? (Please check all that apply)

   ___ Breathing exercises
   ___ Rest/relaxation
   ___ Drink liquids

   Takes medications: ___ Inhaler ___ Nebulizer ___ Oral medications

   Other (please describe)_____
6. Does the student carry MDI (Meter Dose Inhaler) at school? _____Yes _____No

7. Please list ALL medications your child takes for asthma or for any other need.

   Name of medication | Dose | Frequency

   _____

8. Side effects of medication your child may or has experienced: _____
9. Does your child use a peak flow meter? ____ Yes ____ No

   If yes, what is child's current best peak flow? _____
10. Additional information/instructions: _____
11. Control of school environment: (List any environmental control measures, pre-medications, and/or restrictions that the student needs to prevent an asthma episode):

    _____

    _____

12. Number of times your child has been taken to an emergency facility for an acute attack of asthma in the past 12 months: _____
13. Emergency action is necessary when the student has symptoms such as:

    _____, _____, _____.

14. Have you ever attended an asthma education class? ___ Yes ___ No
    Has your child had asthma education? ___ Yes ___ No
15. What action do you advise school personnel to take if your child develops acute signs of an asthma attack? _____

You will be notified by either the nurse or designated school personnel when your child has breathing difficulty.

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year. Thank you for your cooperation and help in providing the best care for your child.

Parent/Guardian Signature: _____ Date: _____
Home # _____ Cell # _____ Work # _____

Physician/Specialist Name: _____ Phone# _____

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