

Asthma Action Plan

School Year

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Emergency Contact Person:	Contact Phone(s):	
Healthcare Provider Name(s):	Phone:	

- If coughing or wheezing, give:
 - _____ Albuterol 2-4 puffs with/without spacer and notify parent/guardian
 - _____ Albuterol 1 treatment via nebulizer and notify parent/guardian
- Pre-Medication, give:
 - _____ Albuterol 2-4 puffs with/without spacer 15 to 30 minutes prior to exercise.
 - _____ Albuterol 1 treatment via nebulizer 15 to 30 minutes prior to exercise.
- _____ Recommend that school nurse/personnel administer asthma medications and notify parent/guardian
- _____ Recommend that student carry medication and self-deliver as needed

Name of Physician (printed)

Physician Signature

Date

Name of Parent or Guardian (printed)

Parent/Guardian Signature

Date