Odebolt Arthur Battle Creek Ida Grove Asthma Action Plan

Student Name _____ Grade _____

Parent's Name _____ Date _____

Physician treating child's asthma _____ Phone _____

Asthma Severity: ☐ Mild ☐ Moderate ☐ Severe

Frequency of asthma episodes: _____

Is the student involved in sports? ☐ Yes ☐ No Please List _____

Asthma Triggers (What causes an asthma episode)

☐ Exercise	☐ Strong Odors/Perfumes	☐ Animals	☐ Dust
☐ Respiratory Infections	☐ Plants/Pollens	☐ Foods	☐ Molds
☐ Other, please list _____			

Current medications, including inhalers:

Good Asthma Control	Daily Medications – Use Every Day			
Child feels good: Breathing is good/normal No cough or wheeze Can work/play without difficulty Sleeps well at night	Medication	Dose	When to take?	To be taken at school? Y/N

Be Careful	Take Daily Medications PLUS add these Rescue Medications			
Child has any of the following: Cough Mild Wheeze Tight Chest Coughing at night First sign of a cold Exposure to asthma trigger	Medication	Dose	When to take?	To be taken at school? Y/N
	If rescue medication is needed more than 2-3 times a week, then Call Your Doctor			

Child has any of the following: Medication not helping Breathing hard and fast Nasal flaring Bluish lips Bluish fingernails Trouble walking and talking	Medication	Dose	When to take?	To be taken at school? Y/N
	Call 911Now if: Lips are bluish, getting worse fast, struggling to breathe, can't talk because of difficulty breathing, or has passed out.			

Comments/Special Instructions: _____

Inhalers at School: _____ has been instruction on the proper way to use inhalers, and I give permission for my child to carry an inhaler with him/her and use as needed at school. ☐ Yes ☐ No

I request that my child keep the inhaler in the school office ☐ Yes ☐ No

_____ _____

Parent or School Nurse Signature Date

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