

Asthma Action Plan
PARENT OR GUARDIAN TO COMPLETE

Student Name: _____ D.O.B. _____ Program: ERfC

LIST KNOWN ALLERGIES: _____

Known asthma triggers:

- Exercise Pet dander Mold Dust Pollen Colds Strong Odors
 Cold air Pests

STEP ONE – TREATMENT:

Exercise Pre-Treatment Not required Before activity/sports

Rescue medicine to relieve asthma symptoms: exposure to know trigger, cough, chest tightness, wheezing, shortness of breath.

Give Inhaler _____

___ Puffs inhaled (by mouth) every ___ hours with spacer

Document administration of inhaler.

STEP TWO: EMERGENCY CALLS

1. Call 911 if: student is quickly getting worse; medicine is not improving symptoms; breathing is hard and fast; nose opens wide; student can't talk well or is getting nervous.

2. Call Parent/Guardian:

Name/Relationship	Phone #1	Phone #2
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

3. Call ERfC office to report incident

Parent/Guardian Signature _____ Date _____

ERfC Health Care Consultant Signature _____ Date _____

Signature of the staff responsible for _____ (name of child)

Printed Name	Signature	Date Signed	Printed Name	Signature	Date Signed