Botkins Local School

Phone- 937-693-4241 Fax- 937-693-2557

Asthma Action Plan

Student-_____Age_____Grade_____

According to our records you have informed the school that your child has asthma. Please complete the information below. This will help the school staff to know more about how your child reacts to his/her condition and the best way to protect the health and safety of your child while at school. Please return this form to the nurse to add to your students' confidential records. The nurse will inform all appropriate staff regarding this information.

How long has the child had asthma?_____

What is the severity of his/her asthma? 0-10 being severe. Please circle. 0 1 2 3 4 5 6 7 8 9 10

What triggers your child's asthma? Please check all that apply.

___ Illness ___ Emotion ___Medications ___Food ___Weather

___Exercise ___Smoke ___Chemical odors ___Fatigue other_____

Please list allergies:_____

Describe your child's symptoms that they experience; e.g. wheezing, coughing, and tightness

_____

What does your child normally do to relieve his/her symptoms during an asthma attack? Please check all that apply:

___Breathing exercises ___Rest/relaxation ___Drink liquids

Medications ___Inhaler ___Nebulizer ___Oral medications Other_____

Emergency action is needed when they display the following symptoms_____

What action do you advise the school staff to take if your child develops acute signs?_____

Name of Medication Dose Frequency

Does the student carry his/her Inhaler at school? _____Where is it located?_____

Does your child use a peak flow meter?_____What is his/her current peak flow?_____

List any environment control measures, pre-medications, restrictions that the student needs to follow to prevent an asthma episode._____

_____

Please list the number of visits to the emergency room in the past 12 months_____

You will be notified by the school staff if your child has difficulties at school. Please contact the school nurse if you have questions or if your child's health changes. Thank you for your cooperation and help in providing the best care for your child.

Parent/Guardian Signature_____Date_____

Contact numbers in order of preference during school hours

Contact #1_____

Contact # 2_____

Contact #3_____

Physician/ Specialist name_____phone #_____