Eagle PRESCHOOL

Asthma Action Plan

Student Name: _____ Class: _____

1. How long has your child had asthma? _____
2. Rate the severity of his/her asthma. (Circle one) (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)
3. How many days would you estimate he/she missed school last year due to asthma? _____
4. What triggers your child's asthma attack? (Check all that apply)

___ Illness ___ Emotions ___ Pollens/Molds ___ Foods

___ Weather ___ Exercise ___ Odors/Fumes ___ Animals

___ Fatigue Other: _____

5. What does your child do at home to relieve wheezing during an asthma attack?

___ Breathing exercises ___ Uses inhaler ___ Rest/Relaxation

___Uses nebulizer ___ Drinks water ___ Uses oral medication

___ Other: _____

6. Please list your child's medication(s)

Daily medication(s): _____

Medication(s) for asthma symptoms: _____

7. Please list the medication(s) that you will provide for the teacher to keep in the classroom

Medication(s): _____

Symptoms that would indicate the need for the medication: _____

_____

8. If your child suffers a severe asthma attack at school, what plan of action would you prefer school personnel to take? _____

Parent Signature _____ Date _____