DAYTON ISD

Asthma Action Plan

Student Information

Name of Student: _____ DOB: _____
Grade _____ Homeroom Teacher or Class _____
Physical Education Days and Times _____

Emergency Information

Parent(s) or Guardian(s) Name(s) _____
Mother: Telephone (Work) _____ (Home) _____
Father: Telephone (Work) _____ (Home) _____
Physician's name: _____ Telephone: _____
In case of emergency contact:
1. _____
2. _____
3. _____

All Current Medications

Name of Medication	Dosage	Time

Medications to be given at School (if any)

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

Parent's/guardian's signature _____ Date _____

Physician's signature _____ Date _____