School Asthma Action Plan Form

Asthma Action Plan For

_____(Student's Name).

This action plan has been individually designed to help school professionals work with _____ (Student's Name) to control and treat asthma at school. It is based on monitoring peak flow numbers and asthma symptoms.

Name of School:_____

Date of Birth: _____

Grade: _____

Parent(s') or guardian(s') names: _____

Mother Telephone:
(H) _____(W) _____

Father Telephone:
(H) _____(W) _____

Health Care Provider's Name: _____

Type of Insurance: _____

In case of emergency, contact:

Name: _____ Telephone: _____
Relationship: _____

Name: _____ Telephone: _____
Relationship: _____

Hospital Preference if 911 is called: _____

If peak flow number is from _____ to _____ (Yellow Zone) or you notice any of these symptoms _____
1. _____
2. _____

If peak flow number is from _____ to _____ (Red Zone) or you notice any of these symptoms _____
1. _____
2. _____

PARENT SIGNATURE / DATE

_____

PHYSICIAN SIGNATURE / DATE

_____