CATOOSA COUNTY PUBLIC SCHOOLS
ASTHMA ACTION PLAN

School: _____ **School Year:**_____ **Date:** _____

Student Name:_____ **DOB:**_____

Teacher: _____ **Grade Level:**_____

Parent/Guardian: _____

#1 Phone: _____ **#2 Phone:** _____

Emergency Contact: _____ **Phone #:** _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release information regarding my child's health condition. I understand that this health information will ONLY be shared with pertinent school staff.

_____ _____

Parent/Guardian Signature **Date**

COMPLETED BY PHYSICIAN:

MEDICAL DIAGNOSIS: _____

PAST MEDICAL HISTORY:_____

_____

CHECK TRIGGERS THAT START THIS STUDENTS ASTHMA ATTACK:

☐Respiratory Infection	☐Chalk Dust/Dust	☐Changes in Temperature
☐Carpets in the Room	☐Pollens	☐Emotional Stress
☐Molds	☐Animals	☐Food
☐Exercise	☐Allergic Reaction	☐Odors

☐Other:_____

CHECK SIGNS/SYMPTOMS THAT MAY BE PRESENT WITH ASTHMA ATTACK:

☐Cough ☐Difficulty Breathing ☐Wheeze ☐Chest Tightness

Other: _____

Turn Form Over

Student:_____

MEDICATION REGIMEN: (List control medications, quick relief inhaler, nebulizer, etc.)

Medication Name	Dosage	When To Use

☐ **Medicate with quick relief inhaler 10-20 minutes before activity.** (Check if applies.)

INDIVIDUAL CONSIDERATIONS: (Please indicate any special diet, physical activity limitations/adaptations, special interventions, protective equipment and/or impact on school attendance.)_____

_____

_____

☐ Is peak flow meter used? (Check if used at school and explain)_____

_____

_____

FOR INHALED MEDICATIONS:

☐ I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that _____ should be allowed to carry and use the medication by him/herself.

☐ It is my professional opinion that _____ should NOT carry his/her medication by him/herself.

_____ _____

Physician's Signature **Date**

Physician Address/Phone/Fax