

HEALTH INFORMATION PLAN ASTHMA ACTION PLAN

Name of Child: _____ Date of Birth: _____

Child's Age: _____ Homeroom Teacher: _____ Grade: _____

Emergency Information:

Parent(s) or Guardian(s) Names: _____

Mother's Telephone (work) _____ Father's Telephone (work) _____

Cell _____ Cell _____

Home _____ Home _____

Pulmonologist _____ Telephone _____

Primary Care Physician _____ Telephone _____

In the event a parent/guardian cannot be reached:

1. _____ Relationship _____ Telephone _____
2. _____ Relationship _____ Telephone _____

Preferred Local Emergency Department _____

Triggers that may bring on an asthma episode: (please check all that apply)

<input type="checkbox"/> Cigarette smoke	<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Allergic reactions, such as food or insects (describe)
<input type="checkbox"/> Exercise	<input type="checkbox"/> Odors	<input type="checkbox"/> Paint fumes
<input type="checkbox"/> Exposure to cold air	<input type="checkbox"/> Respiratory infection	<input type="checkbox"/> Other (carpets, chalk dust, etc.)

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Time of Day

List any environmental measures, pre-medications or dietary restrictions needed to prevent an asthma episode:

Signs and symptoms: (please check the symptoms that occur in your child)

<input type="checkbox"/> Cough	<input type="checkbox"/> Fear	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Bluish color skin/nails	<input type="checkbox"/> Tired	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Unable to speak without taking a breath		<input type="checkbox"/> Other

Does child use a peak flow meter: Yes No If yes, Daily Occasionally Personal Best Peak Flow _____

My child has the following other chronic illnesses/disabilities: _____

Allergies: _____

Child's Limitations or Special Considerations: _____

I understand that it is my responsibility to keep this information current. Please notify the School Nurse and provide an updated/current form on an annual basis.

Parent's/Guardian's Signature: _____ Date _____