

ASTHMA ACTION PLAN

All Current Medication: (Please indicate if student carries inhaler on person, comes to the office or inhaler or both)

Name of Medication	Dosage	Time

Medication to be given at school (if any)

Name of Medication	Dosage	Time

Steps that parents want followed of an Acute Asthma Episode

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

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

Teacher's signature: _____ Date: _____

Physician's signature _____ Date: _____