Sand Springs Public Schools

Asthma Action Plan

TO BE FILLED OUT BY PARENT/GUARDIAN ***AND*** PHYSICIAN

General Information:

Name of Student _____ School _____

Emergency Contact _____ Phone _____

Physician Treating Student for Asthma _____ Phone _____

Daily Asthma Management Plan

Triggers (check each that applies to the student)	Exercise
❍ Colds ❍ Smoke ❍ Weather ❍ Exercise ❍ Dust ❍ Air pollution ❍ Animals ❍ Food ❍ Strong odor ❍ Other _____	1. Pre-medication (how much and when) _____ _____ 2. Exercise modifications _____ _____

Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)_____

_____

Daily Medication Plan

	Name	Amount	When to Use
1			
2			
3			
4			

Comments/Special Instructions

_____

_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____

_____ or has a peak flow reading of _____.

Emergency Asthma Medications

	Name	Amount	When to Use
1			
2			
3			

Physician Signature (required) _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Physician must also fill out and sign medication authorization form if medication will be taken at school.