ASTHMA ACTION PLAN

Springfield School District

School Health Department

You have indicated that your child has asthma. To provide the best care for him/her at school, I am requesting some additional information about your child and his/her asthma. Please complete the attached form and return it to your school nurse as soon as possible. Some of these questions may not apply to your child and those may be left blank. Please contact the School Nurse with any changes during the school year.

**Please note there is a physician portion on reverse side if your child needs medication at school.

Student Name:____ Grade/HR:________________

Parent's name:____ Home Phone:__________________

Work Phone:________________________ Cell Phone:_______________________

Name of Child's doctor (for asthma):___________________________ Phone :_____________________

How long has your child had asthma?________________

Please rate the severity of his/her asthma (circle)

(Not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate he/she missed school last year due to asthma? ___________

What triggers your child's asthma attacks? (Please check any that apply)

___Illness	___Emotions	___Medications
___Weather	___ Exercise	___Cigarette or other smoke
___ Chemical Odors	___Fatigue	___Respiratory Infections
___Animals	___Foods	___Molds, Pollens

Describe symptoms your child experiences (wheezing, coughing, tightness, etc.)

Please list the medications your child takes for asthma (both daily and as needed).

	Name of Medication	Dose	Frequency
At Home	________________________	_________	_______________
	________________________	_________	_______________
	________________________	_________	_______________

	Name of Mediation	Dose	Frequency
At School	____________________	________	________________
	____________________	________	________________
	____________________	________	_________________

What, if any, side effects do your child have his/her medications? _______________________________

Do you know your child's peak flow rate? Yes _____   Rate ________   No _______

If your child does not respond to medication, what action do you advise the school nurse to take?

_ ____

How often does your child have an asthma episode? ____________________________________

How many times has your child been treated in the emergency room for asthma this past year? ______

How often does your child see his/her doctor for a routine asthma evaluation? ___________

Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly).

Modified Gym Class ____

Modified outdoor recess ____

No animals or pets in classroom ____

Avoid certain foods ____

Emotional or behavioral concerns ____

Special considerations on field trips ______________________________________

Signature of Parent/Guardian: ______________________________________ Date:____________

PHYSICIAN SECTION

Name of medication:________________________________

Indication: ____

Scheduled dosage/usage/route:___________________________

Physician Signature:_________________________________