ASTHMA ACTION PLAN

Nurse Phone: 516-7287

Nurse Fax: 516-8462

Student's Name: _____ Grade/Teacher: _____

Health Care Provider: _____ Phone:_____ Fax:_____

Parent/Guardian:_____ Home:_____ Cell:_____

Alternate Emergency Contact Name:_____ Phone:_____

Circle known Asthma Triggers for this student:

Colds Exercise Animals Dust Smoke Food Weather Fragrance Other: _____

Daily Maintenance Medications:	**Dosage:**	**Frequency:**
1.		
2.		
3.		

PLEASE TAKE _____PUFFS of _____INHALER _____MINUTES BEFORE PE (GYM) CLASS

Personal Best Peak Flow Number_____ Monitoring Times: _____

Rescue Medications:	**Dosage:**	**Frequency:**
1.		
2.		
3.		

Please check one:

☐ Student has been instructed on self-administration and is capable of responsibly carrying his/her own inhaler during school hours. Student will notify nurse if used during school hours. **Dover Middle School Nurse will not be responsible for medication effects or for ensuring that it is taken. Student will be responsible for taking his/her own inhaler on field trips.**

☐ Student should not self-carry his/her inhaler: inhaler should be kept in the Nurse's Office. **Inhalers kept with the nurse will be packed by the nurse for field trips.**

I give permission for the School Nurse to share information about my child's asthma with staff and faculty of Dover Middle School. I allow the School Nurse to communicate with my child's Health Care Provider regarding his/her asthma. I will notify the School Nurse of any medication/treatment changes.

Parent Signature: _____ Date:_____

Health Care Provider Signature:_____ Date:_____