Student Asthma/Allergy Action Plan

Name ____ Grade______ Age______

Parents/Guardians ____

Identify the things which start an asthma episode or allergic reaction: (check all that apply)

- ❑ Exercise
- ❑ Respiratory Infection
- ❑ Change in temperature
- ❑ Cold air
- ❑ Humidity
- ❑ Perfume
- ❑ Aerosol sprays
- ❑ Dust
- ❑ Mowed grass
- ❑ Strong odors or fumes
- ❑ Chalk dust
- ❑ Carpets in rooms
- ❑ Tobacco smoke
- ❑ Pollens ____
- ❑ Molds ____
- ❑ Animals ____
- ❑ Foods ____
- ❑ Other ____

Control of environment: (list any environmental control measures, pre-meds and/or dietary restrictions which the student needs to prevent allergy or asthma episode)

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Permission/Signatures

From Physician

- ❑ I have instructed ______________________ in the proper use of all his/her asthma and/or allergy medications. In my opinion the student should be able to carry and use his/her inhaler or rescue medications while at school.
- ❑ In my opinion the student should not be able to carry his/her inhaler or rescue medications while at school.
- ❑ In my opinion the treatment plan indicated on the back of this Asthma Action Plan is appropriate for this student and school staff may use it to treat the student.

Physician Signature: ________________________________ Date: __________

Physician Name Printed: ________________________________

From Parent/Guardian

______________________ School has my permission to follow this Student Athma/Allergy Action Plan for my child, ________________________________.

Parent Signature: ________________________________ Date: __________