

Student Asthma Action Card



lame:			Grade:	Age:	
Iomeroom Teach	er:		Room:		
arent/Guardian	Name:		Ph: (h):		ID Photo
	Address:		Ph: (w):		
Parent/Guardian	Name:		Ph: (h):		
	Address:		Ph: (w):		
mergency Phone	e Contact #1				Pl
. Di	G !!Q	Name	Rel	ationship	Phone
mergency Phone	e Contact #2	Name	Rel	ationship	Phone
hysician Treatin	g Student for Asthi	ma:		Ph:	
other Physician:				Ph:	
Emergency					
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		the student has sympt			. ,
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DAILY ASTHMA MANAGEMENT PLAN • Identify the things which start an asthma episode (Check □ Exercise □ Strong odors or □ Respiratory infactions

 Identify the things which start an asthr 	ma (episode (Check each th	at app	nes to the stu	dent.)
□ Exercise		Strong odors or fumes		Other	
☐ Respiratory infections		Chalk dust / dust			
☐ Change in temperature		Carpets in the room			
☐ Animals		Pollens			
□ Food		Molds			
Comments					
Control of School Environment					
(List any environmental control measures, pre-repisode.)					
Peak Flow Monitoring					
Personal Best Peak Flow number:					
Monitoring Times:					#c s
Daily Medication Plan					
Name		Amount			When to Use
1					
2					
3.4561					
4.					
COMMENTS / SPECIAL INSTRUCTIONS	5				
FOR INHALED MEDICATIONS					
☐ I have instructed		in the pr			
professional opinion thathim/herself.		should b	e allow	ed to carry and	use that medication by
☐ It is my professional opinion that		should not carry h	is/her i	nhaled medicati	on by him/herself.
Physician Sign	atur	9			Date
Parent/Guardia	ın Si	gnature	-]	Date