STRAFFORD ELEMENTARY SCHOOL

STUDENTS' ASTHMA EMERGENCY ACTION PLAN

Name: _____ D.O.B: _____ Age: _____
Teacher: _____ Grade: _____

Parent/Guardian Name: _____ Ph: (h)_____ (w)_____
Name: _____ Ph: (h) _____(w) _____

Emergency Contact : _____
Name Relationship Phone

TREATING PHYSICIAN:_____ **Phone**:_____
OTHER PHYSICIAN: _____ Phone: _____

Asthma History:

1. At what age did your physician diagnosis your child's Asthma? _____
2. Please rate the severity of your childs Asthma (circle)
   (Not severe) **0 1 2 3 4 5 6 7 8 9 10** (severe)
3. How often does your child visit the physician for routine asthma evaluations? _____
4. Does your child also have Allergies (medications, environ. etc.) ? **Y or N**
   If yes, please explain: _____
   _____

Daily Asthma Management Plan

***** Identify the things which start an asthma episode (check all that apply)

__ Exercise	__ Strong odors or fumes	__ Molds
__ Respiratory infect	__ Carpets in rooms	__ Pollens
__ Change in temp	__ Animals	__Chalk dust
__ Other _____		

Peak Flow Monitoring

Peak Flow Used at Home: **Y** or **N** Personal Best Number: _____
Spacer: **Y** or **N**

Daily Medication Plan (include **all** medications taken)

	Name	Dose	When
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

What, if any, side effects does your child have from these medications :_____
_____
_____

Parents/Guardian Signature: _____ **Date:** _____
Parents/Guardian Name PRINTED:_____

Reverse filled out by Physician