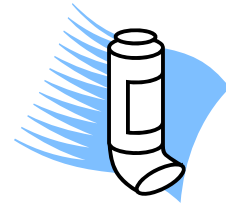


ASTHMA ACTION PLAN
(To Be Completed by Physician & Parent)



Student Name/Grade _____

Describe Asthma "Triggers" _____

Doctor's Name _____

Steps to be taken during Asthma attack:

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medicine:

Special precautions for gym class or recess:

Physician's Signature

Date

Address

Telephone

Parent's Signature

Date

Home Telephone

Work Telephone

If your child needs to keep medicine at school, please have your physician fill out the form on the reverse side of this questionnaire. You and your physician must sign it. All medications, including inhalers not specified to be carried by the student, must be kept in the health office.