Our Lady Help of Christians Academy

Asthma Action Plan
2016-2017 Academic Year

Part I: To be completed by parent or guardian

Date:_____

Name of Student: _____ Grade:_____

Person(s) to notify in case of an acute asthma episode:

_____ _____
Name and relationship to student *telephone*

_____ _____
Name and relationship to student *telephone*

Physician:

_____ _____
Name of physician (first and last) *telephone*

_____
Physician street address *City, State, ZIP*

Part II:To be completed by physician

Steps to take if student has an acute asthma episode:

1. _____
2. _____
3. _____

Medications used and dosages:

1. _____
2. _____

List of allergens or asthma triggers. If unknown, please write "Unknown.":

1. _____
2. _____
3. _____

Signed _____ _____
Physician Signature *Date*

Form Revised 06-2016