ASTHMA ACTION PLAN

Collingdale Nazarene Christian School (CNCS)

Place Child's Photo Here

You have indicated that your child has asthma. To provide the best card for him/her at school, CNCS is requesting some additional information about your child and his/her asthma. Please complete the attached form and return it to the CNCS Principal as soon as possible. Some of these questions may not apply to your child and those may be left blank. Please contact the CNCS Principal with any changes during the school year.

**Please note there is a physician portion on reverse side if your child needs medication at school.

Student Name:_____ Grade/HR:_____

Parent's name:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Name of Child's doctor (for asthma):_____ Phone :_____

How long has your child had asthma?_____

Please rate the severity of his/her asthma (circle)

(Not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate he/she missed school last year due to asthma? _____

What triggers your child's asthma attacks? (Please check any that apply)

___Illness	___Emotions	___Medications
___Weather	___ Exercise	___Cigarette or other smoke
___ Chemical Odors	___Fatigue	___Respiratory Infections
___Animals	___Foods	___Molds, Pollens

Describe symptoms your child experiences (wheezing, coughing, tightness, etc.)

Please list the medications your child takes for asthma (both daily and as needed).

	Name of Medication	Dose	Frequency
At Home	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

	Name of Mediation	Dose	Frequency
At School	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

What, if any, side effects do your child have his/her medications? _____

Do you know your child's peak flow rate? Yes _____ Rate _____ No _____

If your child does not respond to medication, what action do you advise the school nurse to take?

_ _____

How often does your child have an asthma episode? _____

How many times has your child been treated in the emergency room for asthma this past year? _____

How often does your child see his/her doctor for a routine asthma evaluation? _____

Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly).

Modified Gym Class _____

Modified outdoor recess _____

No animals or pets in classroom _____

Avoid certain foods _____

Emotional or behavioral concerns _____

Special considerations on field trips _____

Signature of Parent/Guardian: _____ Date:_____

PHYSICIAN SECTION

Name of medication:_____

Indication: _____

Scheduled dosage/usage/route:_____

Physician Signature:_____