CARMEL UNIFIED SCHOOL DISTRICT- HEALTH SERVICES

ASTHMA ACTION PLAN

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

STUDENT NAME:_____ DOB:_____

PARENT/GUARDIAN:_____ PHONE:_____

OTHER EMERGENCY CONTACT:_____ PHONE:_____

TREATING PHYSICIAN:_____ PHONE:_____

Asthma Triggers:

Pollen		Food	
Mold		Exercise	
Dust Mites		Cold/Flu	
Animals		Weather	
Smoke		Air Pollution	

Daily Control Medication at Home: Yes ☐ No ☐

Medication: _____

Dose: _____ Time Given: _____

Quick relief Medication When Symptoms Occur at School:

Medication: _____

Dose:_____ Frequency: _____

Preventative Medication before Exertion or Exercise at School:

Medication: _____

Dose:_____ _____Minutes Prior to Exercise

If the student experiences any of the following, call 911 and contact the parents

Rescue inhaler is not working, severe breathing difficulty, turning blue, difficulty talking

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____