Savannah-Chatham County Public School System

ASTHMA ACTION PLAN

IMPORTANT-This form must be signed by a physician and returned to the nurse for any student requiring asthma medication management. Additionally, physician authorization is required on this form as well as on a self-administration form for any student wishing to self-administer medication.

Name: _____ Grade: ____ Age: _____ School: _____

Parent/Guardian Name: _____ Phone:(W): _____ (C): _____

Address: _____ Phone(H): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone #: _____

Important! Things that make your child's asthma worse (Triggers): ☐ smoke ☐pets ☐mold ☐dust ☐trees ☐grass ☐weeds ☐pollen ☐colds/viruses ☐exercise ☐seasons: _____ ☐other: _____

Severity Classification: ☐Severe Persistent ☐Moderate Persistent ☐Mild Persistent ☐Intermittent.

PHYSICIAN PORTION

DAILY MEDS: Use these medicines every day to prevent symptoms.

You have *all* of these:	**Daily Medicine**	**Amount**
• Breathing is good	_____	_____
• No cough or wheeze	_____	_____
• Can work and play	_____	_____

PRE-EXERCISE MEDS:	**Pre-Exercise Meds**	**Amount**
	_____	_____
Yes **No**	_____	_____

RESCUE MEDICINE – Slow Down! Continue with Daily Medicine and Add:

You have any of these:	**Rescue Medicine**	**Amount**
• Wheeze	_____	_____
• Cough	_____	_____
• Tight chest	_____	_____
• Shortness of breath		

EMERGENCY MEDICINE - Asthma is getting worse fast: Give Emergency Medicines, get help immediately, contact parent or emergency contact.

You have these:	**Emergency Meds**	**Amount**
• Medicine is not helping within 15-20 minutes	_____	_____
• Breathing is hard and fast	_____	_____
• Chest or neck pulled in with breaths		
• Lips/fingertips gray or blue		
• Trouble walking or talking		

Physician Signature: _____ Date: _____

Form revised 06/28/2018