Weston Public Schools

Asthma Action Plan

Student Information

Name of Student _____ D.O.B. _____

Grade _____ Homeroom Teacher or Class _____

Physical Education Days and Times: _____

Emergency Information

Parent/Guardian Name: _____

Parent/Guardian Home Phone: _____ Cell Phone: _____ Business Phone: _____

Parent/Guardian Name: _____

Parent/Guardian Home Phone: _____ Cell Phone: _____ Business Phone: _____

In case of emergency, contact:

1. _____

2. _____

3. _____

Asthma Emergency Action

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

- Activate the emergency medical system in your area. Phone: _____
- Call Parent/Guardian or Physician

Circle all applicable triggers:

Air	Bee	Cats	Chalk	Cold
Dogs	Dust	Foods	Humidity	Molds
Perfumes	Pollen	Smoke	Venom	Viral Infection

Other/Specify _____

Usual Symptoms _____

Personal best peak flow: _____

Individual peak flow guidelines: _____

All Current Medications Taken At Home

Name of Medication	Dosage	Time

Medications To Be Given At School (if any)

Name of Medication	Dosage	Time

Medications Are Kept: (please circle)

By Student By Teacher In School Office In Nurse's Office

Steps for an acute asthma episode:

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

I give permission to the school nurse and other designated staff members of_____ _____School to perform and carry out necessary tasks as outlined by _____'s Asthma Medical Management Plan. I also consent to the release of the information contained in this Asthma Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____
Student's Parent/Guardian Date

_____ _____
Student's Parent/Guardian Date

_____ _____
School Nurse Signature Date