Merion Mercy Academy

Asthma Action Plan

Student's Name:_____ Grade:_____Date of Birth:_____

Parent/Guardian: _____ Phone/Cell:_____

Emergency contact: _____ Phone/Cell_____

Physician: _____ Phone:_____

Rate Asthma:

__ mild intermittent ___mild persistent __mod persistent __severe persistent

Asthma triggers:_____
What are the side effects of student's medication? _____
How often does the student have an asthma episode?_____
What special considerations related to asthma does the student need while at school? _____

Asthma medications taken at home:_____

Asthma medications to be taken at school**:**_____

If no response to medication, what action do you advise the school nurse to take?

*****Please inform the school nurse of any changes in your student's medical condition*****

Student has permission to self carry medication /inhaler _____ **yes** _____ **no**

Signature of Prescribing Physician_____Date _____

Signature of Parent/Guardian _____Date _____