DAYTON PUBLIC SCHOOLS

ASTHMA ACTION PLAN

Date______________

Child's Name____ Home Phone__________
Parent / Guardian Name____________________________________Work Phone___________
Address____Cell Number__________
Physician treating child's asthma______________________________Phone________________

In case of emergency and unable to reach parent, please contact:
____Phone_______________
____Phone_______________

What symptoms does your child have when having an asthma attack?

Briefly describe what causes your child's symptoms

In which sports can the child fully participate?

Does exercise bring on episodes of asthma? (If so, what types?)

Do certain weather conditions affect your child's asthma? (If so, list them)

Approximately how often does the child have an acute episode?

How do you want the school to treat an episode of asthma if it should occur?

Signature of Parent or Guardian____

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To be completed by Child's Physician:

Personal best Peak Flow number__________________
Caution zone Peak Flow numbers__________________
What steps should school take if Peak Flow numbers are in the caution zone?________________________
____

Danger Peak Flow numbers____

If any asthma medications may need to be given at school, please complete and sign attached medication form

Signature of Physician_____Date_____