Last Name Mother	First Name	Home Phone	Work Phone	Cell Phone
Last Name Father	First Name	Home Phone	Work Phone	Cell phone
Last Name Emergency Contact	First Name	Home Phone	Work Phone	Cell Phone

Please complete the remainder of this update and sign below. If your son/daughter has significant changes, please inform the school health office.

1. What things "trigger" or cause your son's/daughter's asthma symptoms?

_____

_____

2. Does exercising cause an asthma episode? ☐ Yes ☐ No
If yes, should he/she pre-treat 15 minutes prior to exercise with an inhaler? ☐ Yes ☐ No
Inhaler to be used and dose:_____

3. What are the usual symptoms your son/daughter experiences during an asthma episode, e.g. coughing, wheezing, etc?

_____

_____

4. Has your son/daughter required emergency room treatment for his/her asthma? ☐ Yes ☐ No
If yes, please describe details and date of the last ER visit:

_____

5. If we have questions about your son's/daughter's asthma/medications, may we contact the physician?
Yes _____ No_____ Physician's name _____Phone ( )_____

PLEASE PROVIDE THE APPROPRIATE MEDICATION WITH PARENT'S WRITTEN PERMISSION AND PHYSICIAN'S WRITTEN ORDERS WITH SPECIFIC INSTRUCTIONS FOR ITS USE. "USE AS DIRECTED" IS NOT SUFFICIENT. ***IF THE INHALER IS TO BE CARRIED BY THE STUDENT, THE DOCTOR'S NOTE MUST STATE THAT. (see physician's statement on front page)***

I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate.

_____ _____
Parent/Guardian Signature Date

Action Plan reviewed by: _____ _____
School Nurse Signature Date

Dates and names of school staff informed of action plan:

_____

_____

*This student demonstrates knowledge and skill to carry and use the prescribed inhaler: Yes___, No___
School Nurse Signature_____ Date: _____