FREEPORT AREA SCHOOL DISTRICT
ASTHMA ACTION PLAN

In order to provide for the special needs of your child while he/she is at school and to be in compliance with state mandated regulations, we must have **ALL** medication/asthma forms in this packet completed and returned to the school nurse immediately. Please notify the school nurse if changes occur during the school year.

Child's name _____Birth date _____Grade _____

Telephone number _____Age asthma was diagnosed _____

1. What triggers asthma symptoms in your child? Include items such as exercise/environment/food allergy, etc.

_____

_____

2. Approximately how often does your child have an acute episode?

_____

3. Does your child understand how to manage it? _____

4. In event your child has an asthma attack during the school day, what procedures would you like the school to follow? (**Be very explicit**).

_____

_____

_____

5. **Special Precautions** for GYM class, and/or Sports Participation, or Recess:

_____

_____

6. If your child is on daily medication <u>at home</u> for asthma, please identify:
   Name of the drug(s) _____
   _____

7. If your child is bringing an inhaler or other asthma medication to school, please identify:
   Name of the drug(s) _____
   _____

If your child needs to have medication at school, please have your physician fill out the Medication Procedure Form in this packet. You and the physician must sign it. All medications, including inhalers not specified to be carried by the student, must be kept in the health office.

_____ _____

(Parent/Guardian Signature) (Today's Date)