City of Sparks Parks & Recreation

Asthma Action Plan

Child's Name: _____ Sex: ____ DOB: ___/___/___ Age: ____

School/Program: _____ Grade: ____

In Case of Emergency Contact:

Name: _____ Relationship: _____

Preferred Phone Number: _____ 2nd Phone Number: _____

Physicians Name: _____ Phone: _____

Signs and Symptoms of child's Asthma:

- _____
- _____
- _____

Triggers:

- _____
- _____
- _____

Medications:

- _____
- _____
- _____

Action plan to implement if symptoms are present:

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

I give permission for the administration of the medication, according to the instructions listed, to the child listed above.

_____

Signature (parent/guardian) **Date of authorization**