PRINCE WILLIAM
Parks, Recreation & Tourism

Asthma Action Plan

Child's Name: _____ DOB: _____

Check All Personal Asthma Triggers Which Apply:

- ☐ Cats and/or Dogs
- ☐ Humidity
- ☐ Molds
- ☐ Dust/Dustmites
- ☐ Fumes and/or Smoke
- ☐ Cold Air
- ☐ Respiratory Infections
- ☐ Other: _____

STEP 1 – ASSESSMENT

Usual Asthma Symptoms Include: _____

Symptoms	Medication	How Much?	How Often?
Tightness in Chest			
Coughing/Wheezing			
Harsh Wheezing			
Difficulty Breathing			

Special Instructions: _____

If child has any of the following danger signs call 911 immediately:

- **Chest sucking in**
- **Very difficult breathing**
- **Nostrils wide-open**
- **Trouble talking or walking**
- **Lips or fingernails blue or purple**

STEP 2 – TREATMENT

Give above medication as directed. Child may administer, or if necessary staff may administer medication.

STEP 3 - EMERGENCY CALLS

Parents:_____

Phone: _____ Phone: _____

EMERGENCY CONTACTS

1. _____

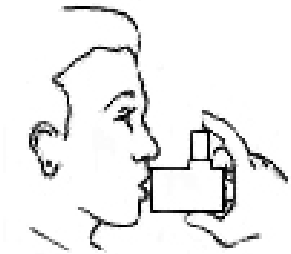
Relation: _____ Phone**:** _____

2. _____

Relation: _____ Phone**:** _____

A. Hold Inhaler 1 to 2 inches in front of your mouth (about the width of two fingers

B. Use a spacer/holding chamber. These come in many shapes and can be useful to any patient.



C. Put the inhaler in your mouth. do not use for steroids.

STEP 4 - Prescription Medication: Health Care Provider to Complete (one form for each medication)

Name of medication: _____

Diagnosis/condition for which medication is being administered: _____

Dosage: Route: _____ Time of administration: _____

Length of time: _____ School year: _____ Other: _____

Possible side effects: ☐ None expected Specify: _____

Health Care Provider Signature: _____

Health Care Provider Printed Name/Stamp: _____

Health Care Provider Phone Number: _____ Fax: _____

Health Care Provider Address: _____