LICKING VALLEY LOCAL SCHOOL DISTRICT
ASTHMA ACTION PLAN

Place Student's Picture Here

To be completed by Physician

Effective ___/___/___ to ___/___/___

Child's Name_____

Address_____

Date of Birth_____

Room Number_____ Teacher_____

PART 1: Medications taken at **HOME** only:_____

PART 2: I certify that it is essential to the health of this child that asthma medication be administered at school.

A. Rescue Inhaler

Medication	Dosage	When to take

B. Rescue Inhaler (Check all that apply)

- ○ First sign of cold
- ○ Mild Wheeze
- ○ Tight Chest
- ○ Cough
- ○ Other _____

PART 3: Emergency Calls

1. Call 911 (requesting paramedics).

2. Call Dr._____at_____

3. Call Emergency Contacts:
   1:_____
   2:_____

Parent/Guardian Signature_____Date_____

Physician Signature_____Date_____

Staff Use only
Received by: Date: