

**LICKING VALLEY LOCAL SCHOOL DISTRICT  
ASTHMA ACTION PLAN**

To be completed by Physician

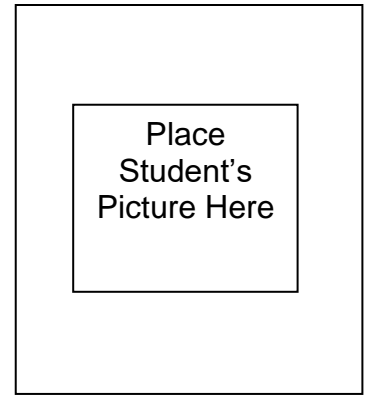
Effective \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

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
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**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: _____
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