Allegheny Valley School District
School Health Services
Asthma Action Plan

According to the health information that you provided, your child has been treated and/or diagnosed with asthma. Please complete the following form to assistant the school nurse in developing an individualized asthma plan for your child. If you wish to discuss the plan, please call the school nurse.

Student Name:_____ **DOB:**_____ **GRADE:**_____

Asthma triggers: _____

Activity restrictions: _____

Daily or Routine Medications: Needed at school? _____ yes ____ no

1. Medication _____
   Dose _____
   Frequency _____

2. Medication _____
   Dose _____
   Frequency _____

Emergency Contact Information

#1 Parent/Guardian _____

Phone: (h) _____ (w) _____ (c) _____

#2 Parent/Guardian _____

Phone: (h) _____ (w) _____ (c) _____

Physician/Healthcare Provider :_____

Phone:_____ address: _____

Required Signatures:

This Asthma Action Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Signature Date

_____ _____
Parent/Guardian Signature Date