# PBS Student Asthma Action Form

Date: _____ Students Name: _____

Grade: _____ Homeroom Teacher: _____

Physician treating asthma: _____ Student's Age: _____

Parent/Guardian: _____ Cell Number: _____

Parent/Guardian: _____ Cell Number: _____

**Identify the thing(s) in which start an asthma episode for your child (please circle all that apply):** Exercise Respiratory Infections Change in temperature Grass Animals Dust Strong odors/perfume Food: _____ Carpet Pollen Mold Other(s): _____

## Daily Medication Plan:

Medication Name: _____

Amount (puffs): _____ When: _____

## As Needed Medication Plan:

Medication Name: _____

Amount (puffs): _____ When: _____

## Emergency Medication Plan:

If student does not respond to above treatment within 15-20 minutes, then parent(s) will be contacted. 911 will be phoned if unable to reach a parent and/or child is experiencing a hard time breathing, constant coughing, gasping, trouble walking or talking, and/or lips start to turn blue.

Signature of Parent/Guardian: _____