Preschool Plan of Action

Asthma and Reactive Airway Disease

Child's Name: _____ Date: _____

Plan of Action (Describe what you would like us to do if your has an exacerbation while at school. Please contact your pediatrician if you are unsure):

_____

_____

_____

_____

An Asthma Action Plan from your child's physician is preferable to keep on file as well, if applicable.

We have a **blank Physician's Medication Order form in the office to be filled out for each medication** to be given in case of an emergency.

If more than one respiratory treatment is required/needed throughout the day, the child's respiratory status is such that he/she have more individualized care our policy states your child must remain at home.

Parent/Guardian Contact Signature: _____