DISTRICT ADMINISTRATION OFFICE
W156N8480 PILGRIM RD
MENOMONEE FALLS, WI 53051
262.255.8440
Website: sdfm.schoolfusion.us

ASTHMA CARE PLAN

School Year: _____

Student's Name: _____ School: _____

Date of Birth: _____ Gender: _____ Grade: _____

Parent/Guardian's Name: _____

Mailing Address: _____

Home Phone: _____ Work Number: _____

Cell Phone: _____

Physician: _____Physician's Number: _____ Fax: _____

Allergies to: _____

Medications		
Name	**Dosage**	**Time**

Does your child experience any side effects or behavior changes from these medications?

_____

_____

Briefly describe what triggers your child's asthma symptoms: **(please circle what applies)**

Smoke Weather Other _____
Exercise Allergies List Symptoms: _____
Dust Emotions _____

Comments:

_____

_____

_____

Approximately how often does your child have an asthma attack? _____

When was your child's last asthma attack? _____

What interventions work best with your child's symptoms? _____
_____

What actions should be taken if your child does not respond to above interventions?
_____
_____

_____ Call ambulance 911
_____ Call parent to notify an ambulance call has been made
_____ Transport to _____

Are there any physical activities in which the child cannot fully participate? _____
_____

Any additional information? _____

This information may be shared with all appropriate staff

_____ _____
Student's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Health Care Provider's Signature Date

CARE PLAN REVIEWED WITH SCHOOL PERSONNEL

School Representative Signature(s)	Date