

(To be completed by  
Parent and Physician)

# LONG BEACH PUBLIC SCHOOLS STUDENT ASTHMA ACTION PLAN

ID PHOTO

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ cell: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (W) \_\_\_\_\_ pgr: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ cell: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (W) \_\_\_\_\_ pgr: \_\_\_\_\_

### Emergency Contact Persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Student Sees for Asthma: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child attend an after school program? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, what program \_\_\_\_\_

## DAILY ASTHMA MANAGEMENT PLAN

- Identify the things that start an asthma episode (Check each that applies to the student.)

_____ Exercise	_____ Strong odors or fumes	Other: _____
_____ Respiratory infections	_____ Chalk dust	_____
_____ Change in temperature	_____ Carpets in the room	_____
_____ Animals	_____ Pollens	
_____ Food	_____ Molds	

Comments \_\_\_\_\_

- Peak Flow Monitoring

Personal Best Peak Flow number: \_\_\_\_\_

- Medications Taken Daily at Home

Medicine	Amount	When to Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____