For Clinic Office Use Only
Date: _____ Reviewed By: _____
Inhaler Expiration: _____

Student's Name: _____

Summer 2024

Asthma Reactive Airway Care Plan

DOB: _____ **Grade (2024-2025)**: _____

List other asthma medications taken at home: _____

History:
☐ Asthma
☐ Reactive Airway Disease
☐ Other

Usual Symptoms:
☐ Wheezing
☐ Tightness in chest
☐ Coughing
☐ Difficulty breathing
☐ Other:

Triggers:	
☐ Exercise	☐ Animals
☐ Molds/Mildew	☐ Chalk
☐ Temperature changes	☐ Carpets
☐ Pollen	☐ Respiratory Infections
☐ Strong odors or fumes (room deodorizers, perfumes, fragrances	
☐ Food (specify all)	
☐ Other:	

If student complains of above symptoms give the following rescue medicine without delay:

Treatment: Please check all that apply and sign below:

Note: If only one inhaler is brought to School, that inhaler will be kept in the clinic.

☐ Student is to carry inhaler with back up inhaler stored in the classroom.

☐ Student is not to carry rescue inhaler.

Name of Inhaler #1: _____ Give: _____ puffs every _____ hours

Name of Inhaler #2: _____ Give: _____ puffs every _____ hours

☐ Notify parent when the first dose of medicine is not effective.

☐ If no improvement after _____dose(s) of the rescue inhaler, call 911.

☐ Call parents listed below.

☐ Other instructions:

Parent/Guardian (call first)

Name:_____

Phone:_____

Parent/Guardian (call second)

Name:_____

Phone:_____

Emergency Contacts (contacted only if unable to reach both parents)

Name:_____

Phone:_____

Name:_____

Phone:_____

Parent Signature:_____ **Date:**_____

Please return form to:
Rosanna Dennis, Registrar, rdennis@schenck.org.
282 Mt. Paran Road, NW, Atlanta, Georgia 30327 p.404-252-259· f. 470-745-6298