Mason City Schools Health Services Information

Asthma and Allergy Action Plan

Student Information

Name of Student_____D.O.B._____

Grade_____Teacher_____Other_____

Please list and describe in detail allergies or reactions to:

Medicine/Drugs: _____
Foods: _____
Bee/Wasp Stings:_____
Environmental/Seasonal:_____
Other: _____

Do you consider your student's allergy or asthma condition to be life threatening? Yes No

Please list steps you would like the Health Services representative in your student's building to follow for both emergency (if applicable) and non-emergency treatment:

Emergency treatment:
1. _____
2. _____
3. _____

Non-Emergency treatment:
1. _____
2. _____
3. _____

Does your student have asthma that has been **diagnosed** by a physician? _____

What medications are given **daily**? _____

What medications are given **frequently**, but not daily? _____
_____

Do you plan to keep medication on hand in the school clinic? Y N

Does your student have a physician's written order to carry his/her own inhaler? Y N

What are your student's "trigger factors" that result in the above symptoms? _____
_____

Physician_____ Physician Phone #_____

Parent/Guardian Name_____ Phone #1_____ #2_____

Parent/Guardian Signature _____ Date_____