Lackawanna Trail Junior-Senior High School

"Home of the Lions"

ASTHMA ACTION PLAN

Student Information:

Name:_____ D.O.B ___/___/___

Grade_____ Phys. Ed. Days _____ Period _____

Emergency Contact Information:

Parent/Guardian Name(s): _____

Mother: (H)_____ (W)_____

Father: (H)_____ (W)_____

Physician's Name/Phone: _____/ _____

In the event the parents are not able to be reached, whom may we contact?

1. _____/_____
2. _____/_____
3. _____/_____

Asthma Triggers:_____

TREATMENT:

Personal Best Peak Flow Number: _____

All Current Medications:

Medication Name	Dosage	Time

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www.ltsd.org