



Student: _____ DOB: _____

Please list any medications taken daily to manage asthma, including nebulizer treatments.

Name	Dosage	When to Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Emergency action is necessary when my child has symptoms such as:

1. _____
2. _____

Emergency Asthma Medications:

Name	Dosage	When to Use
1. _____	_____	_____
2. _____	_____	_____
Can be repeated for severe breathing difficulty _____ times _____ minutes apart.		
3. _____	_____	_____
Can be repeated for severe breathing difficulty _____ times _____ minutes apart.		
4. _____	_____	_____
Can be repeated for severe breathing difficulty _____ times _____ minutes apart.		

Physician's signature: _____ Date: _____

Parent/Guardian: _____ Date: _____