ONTARIO-MONTCLAIR SCHOOL DISTRICT
Health Services
Symptom Based   Asthma Action Plan

Student Name: _____ Date of Birth: _____ School: _____

Parent/Guardian: _____ Home Phone: _____ Cellular: _____

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home):   Please CHECK box if needed for use at school.

A. *"QUICK-RELIEF"* **Medication Name**	1.	☐ For School *
	2.	☐ For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	1.	☐ For School *
	2.	☐ For School *
	3.	☐ For School *

C. BEFORE PE, Exertion: