



SUMNER COUNTY SCHOOLS



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IHP/SAFETY PLAN: ASTHMA DISORDER**

PHYSICIAN

Name of Child: _____ DOB: _____

ASTHMA RISK: Mild _____ Moderate _____ Severe _____

PHYSICIAN

1. _____
2. _____
3. _____

If _____

If _____ SET/SH _____ AND

PROCEED TO EMERGENCY ACTION PLAN BELOW

EMERGENCY ACTION PLAN

1. _____
2. _____
3. _____
4. SET/SIN _____

NAME	DOB	ADDRESS	PHONE

EMERGENCY PHONE _____

I _____
ALLOWED TO CARRY _____

IT SHOULD NOT _____
