[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Doctor's Name]
[Clinic or Hospital Name]
[Clinic Address]

RE: Asthma Action Plan Renewal for [Patient Name] (DOB: [Patient Date of Birth])

Dear Dr. [Doctor's Last Name],

I am writing to request a renewed and signed Asthma Action Plan for [Patient Name/Myself] for the upcoming [School Year/Calendar Year].

The current medications being used are:

- Reliever/Rescue Inhaler: [Name of Medication]
- Controller/Maintenance Medication: [Name of Medication]
- Other: [List any other relevant treatments]

Please review the current dosages and instructions. If there are no changes needed based on the most recent evaluation, please provide an updated copy of the plan with your signature.

This document is required by [School Name/Employer/Childcare Provider] to ensure proper care and administration of medication if needed. You may send the completed form to me via [Email/Mail/Patient Portal], or I can pick it up from your office on [Date].

Thank you for your time and continued care.

Sincerely,

[Your Signature]
[Your Printed Name]