Asthma Action Plan

Student Photo

Student: _____ Birthdate: _____

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and times: _____

EMERGENCY INFORMATION:

Parent(s) or Guardian(s): _____

Mother: Tel (W) _____ Tel (H/C) _____

Father: Tel (W _____ Tel (H/C) _____

Physician: _____ Tel _____

In case of emergency contact:

1. Name: _____ Tel _____
2. Name: _____ Tel _____

ASTHMA EMERGENCY ACTION:

The following are possible signs of an asthma emergency;

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Tel __911__
- Call parent/guardian or physician

Triggers: _____

☐ **Please check if medication <u>WILL NOT</u> be given at school and parent and physician sign page 2.**

☐ **Please check if medication <u>WILL BE</u> given at school, complete the following AND parent and Physician sign page 2**

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

***** PARENT AND PHYSICIAN SIGNATURE REQUIRED ON PAGE 2 *****

(CONTINUED FROM PAGE 1)

School Transportation:

☐ **Please check if student requires emergency medication while using school transportation**
Special Considerations for School Transportation: (Example: Student keeps inhaler in book bag.)
_____

_____

Authorization for Release:

I hereby give permission for _____to exchange specific confidential information with _____ (Physician/Clinic) on my child _____ to develop more effective ways of providing for the healthcare needs of my child in school.

***** Signature of Parent/Guardian _____ Date _____**

***** Physicians Name _____ Tel _____**

***** Signature of Physician _____ Date _____**

**********SELF-MEDICATION FOR ASTHMA INHALERS**********

Authorization

☐ **Please check if STUDENT is permitted by physician to CARRY and SELF-MEDICATE at school. Complete the following and parent/guardian and physician must SIGN below:**

Date to Begin Administration _____

Date to End Administration _____

Adverse reactions that should be reported to physician:

Adverse reactions for unauthorized user:

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

Other special instructions:

_____

Physician and Parent/Guardian Names and Signatures REQUIRED for Self Medication of Asthma Inhalers:

Physician Name _____ Tel _____

Signature of Physician _____ Date _____

Signature of Parent/Guardian _____ Date _____

Copies must be provided to the principal and to the nurse.