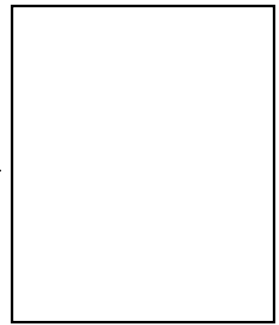


# Asthma Action Plan

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher or Class: \_\_\_\_\_

Physical Education Days and times: \_\_\_\_\_



Student Photo

## 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 **WILL NOT** be given at school and parent and physician sign page 2.

Please check if medication **WILL BE** 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 \*\*\***



**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.

