ASTHMA ACTION PLAN

Student Information:

Student: _____ Birthdate: _____

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and Times: _____

Emergency Information:

Parent(s) or Guardian(s) _____

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

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

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 _____
- Call parent/guardian or physician.

Triggers: _____

- ❑ **Please check if medications *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*****

(CONTINUED FROM PAGE 1)

School Transportation:

☐ Please check if student requires emergency medication while using school transportation

Special Considerations for School Transportation:

_____

_____

Authorization for release:

I hereby give permission for _____school 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_____

Physician 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.