SCHOOL ASTHMA ACTION PLAN

(To be completed at the beginning of each school year and kept on file with the school nurse)

Student's Name _____ Grade _____ DOB _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Physician student sees for asthma _____ Phone _____

Other physician _____ Phone _____

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

☐ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that _____ (student's name) should be allowed to carry and self-administer the following medication while on school property or at school-related events:

A. Bronchodilator (Quick-relief medication):

Name _____

Purpose _____ Dosage _____

When to use _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other medications:

Name _____

Purpose _____ Dosage _____

When to use _____ Additional instructions _____

_____ _____

☐ It is my professional opinion that _____ (student's name) should **NOT** be allowed to carry and self-administer any of his/her asthma medications while on school property or at school related events.

_____ _____

Physician's Signature Date

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events.

_____ _____

Parent/Guardian's Signature Date

DAILY TREATMENT PLAN

Please list any medications taken daily to manage asthma, including nebulizer treatments.

NAME	PURPOSE	DOSAGE	WHEN TO USE
1.			
2.			
3.			

These medications are prescribed for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.) _____

**********EMERGENCY PLAN**********

Emergency action is necessary when this student has symptoms such as:

1. _____ 3. _____

2. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:
    a. Bronchodilator (Quick-relief medication):

        Name: _____ Purpose: _____

        Dosage: _____ When to use: _____

        Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

        Call 911 or EMS if minimal or no improvement.

    b. Other medications:

        Name: _____ Purpose: _____

        Dosage: _____ Purpose: _____

        Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. **Seek emergency medical care if this student experiences any of the following:**

    -No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached

    -Student exhibits:

✓ Chest & neck pulled in with breathing ✓ Struggling to breathe ✓ Stops playing & cannot start activity again

✓ Hunched over while breathing ✓ Trouble walking or talking ✓ Lips of fingernails turn gray or blue

Comments & special instructions: _____

_____

********** **********

Physician's Signature _____ Date _____

I give permission to my child's school to administer daily & emergency medications as necessary, in accordance with physician's instructions above.

Parent/Guardian Signature _____ Date _____