ASTHMA ACTION PLAN

STUDENT INFORMATION (ATTACH PHOTO TO FORM) Date_____

Name:_____ Date of Birth: _____
Class and Teacher:_____

CONTACT INFORMATION

Mother:_____
Home #:_____
Work #: _____
Cell # : _____ Email: _____

Father: _____
Home #:_____
Work #: _____
Cell # : _____ Email: _____

Physician:_____
Work #: _____
Cell # : _____ Email: _____

MEDICATIONS – To be filled out by physician

The student may take the following asthma medication at school, on school provided transportation or at school-related events and activities:

☐ Check here if student may carry and self-administer this asthma medication.

Name of Medication: _____
Purpose of Medication: _____
Dosage:_____
Time Medication should be given:_____
Date to end Medication:_____
Asthma severity classification:_____

☐ Check here if student will not carry this asthma medication, but medication will be kept in Nurse's office.

Name of Medication: _____
Purpose of Medication: _____
Dosage:_____
Time Medication should be given:_____
Date to end Medication:_____

FIRST AID

The following are specific instructions to be followed should the student have an asthma event:_____
_____
_____

PREVENTION

The following allergens or irritants are particularly bothersome to the student:_____
_____

SYMPTOMS

The following are symptoms that may indicate the onset of an asthma event:_____
_____

PARENTAL PERMISSION & RESPONSIBILITIES

I, Parent/Legal Guardian of the above named student, understand and agree to the conditions of the school policy and the action plan. I permit the school to seek emergency medical treatment for the student when deemed necessary and perceived appropriate.

If Student may administer medication:

☐ I give authorization for self-administration and possession of asthma medication by my child while on school property, school provided transportation, or at a school related event or activity, while under supervision of school personnel, and while in before school and after school care on school-operated property. My child demonstrates a full understanding of the proper use of his/her asthma medication.

☐ My child has asthma, but I have chosen not to send medication to school.

I take sole responsibility for:

- Monitoring the asthma medication use, and refilling of prescriptions for asthma medication;
- Ensuring the student always carries his/her asthma medication on his/her person;
- Deciding if backup medication will be kept at the school, and providing the school with the backup medication;
- Informing school staff in writing of any changes in the student's treatment or asthma management or changed medical information; and
- Informing school staff in writing of any medication side effects that the school should notify me about if they occur.

I release and agree to hold the School District and its employees and agents harmless from liability for an injury arising from the student's possession and/or self-administration of prescription asthma medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

Parent Signature: _____
Date: _____

STUDENT AGREEMENT

I, _____, understand and agree to the terms of the asthma action plan.

If student is self-administering medication:

☐ I have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances.

Student Signature: _____
Date: _____

PHYSICIAN APPROVAL

I agree with the above asthma action plan, including the name, purpose, dosage, and administration directions of the asthma medication.

If student is self-administering medication:

☐ It is my professional opinion that the student should be permitted to carry and self-administer his/her asthma medication. The above-named student has been instructed in, and demonstrates an understanding of, the proper use of his/her asthma medication.

☐ Student will not carry and self-administer asthma medication, but medication will be in Nurse's office.

Physician Signature: _____
Printed Physician Name: _____
Date:_____
Address:_____
_____