



ASTHMA ACTION PLAN

Student Information (Attach photo to form)

Date: _____

Name: _____

Date of Birth: _____

Class & Teacher: _____

Contact Information

Mother: _____

Home Tel. #: _____

Work Tel. #: _____

Cell #: _____

Father: _____

Home Tel. #: _____

Work Tel. #: _____

Cell #: _____

Physician: _____

Work Tel. #: _____

Cell #: _____

Medications

The student may take the following medications during school hours:

Check here if student may carry and self-administer these medications.

Name of Medication: _____

Dosage: _____

When Student should take the medication: _____

Name of Medication: _____

Dosage: _____

When Student should take the medication: _____

FIRST AID

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

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 attack: _____

Parental Permission and Responsibilities

I, the 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 appropriate.

If student may administer medication:

I give authorization for self-administration and possession of asthma medication by my child while in school, at school-sponsored activities, 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.

I take sole responsibility for:

- Monitoring the asthma medication, medication use, and refilling of prescriptions for asthma medication;
- Ensuring the student always carries his/her asthma medication of 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 the School District and its employees and agents of any legal responsibility related to my child's possession and self-administration of his or her asthma medication.

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.

Licensed Prescriber Signature:

Date: _____

Name: _____

Address: _____
