Asthma Action Plan

(To be completed yearly and kept on file in the clinic)

Student's Name: _____ DOB: _____Grade: _____School:_____

Father: _____ H: _____ W: _____ Cell: _____

Mother: _____ H: _____ W: _____ Cell: _____

Physician: _____ Phone: _____ Fax: _____

(To be completed by Physician)

Asthma Medication	Dosage/Method i.e. pills, inhaler, nebs	Frequency	Possible Side Effects	Administer 15 before physical exercise	Length of time medication to be kept at school
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

EMERGENCY PLAN

_____can be repeated for severe breathing difficulty _____ times ____ minutes apart.
Medication

******Call parent/legal guardian and/or 911 or EMS if minimal or no improvement***

SELF-ADMINISTRATION OF PRESCRIPTION ASTHMA MEDICINE

☐ 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.

☐ It is my professional opinion that _____ (student's name) ***should*** be allowed to carry and self-administer _____ while on school property or at school-related events. I have instructed the student in the proper way to self-administer the asthma medication(s). The student is knowledgeable about the medication(s) and how to administer it.

Physician's Signature _____ **Phone** _____ **Date** _____

(To be completed by Parent/Guardian)

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

_____/_____/_____
Parent/Guardian (Print) **Signature** **Date**

When applicable, I give permission for my student to self-administer the prescribed medication listed above, in accordance with the physician's order, while on school property or at a school-related event or activity. Self-administration must be done in compliance with the prescription and state law.

_____/_____/_____
Parent/Guardian (Print) **Signature** **Date**