SCHOOL ASTHMA ACTION PLAN

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

Student's Name:_____ DOB:_____ School Year:_____
Parent/Guardian Name(s):_____ Address:_____
Phone Numbers : _____
Emergency Contact(s) and Phone Numbers:_____
Physician Student Sees for Asthma: _____ Phone: _____ Fax:_____
Other Physician: _____ Phone: _____ Fax: _____

IF SYMPTOMS PRESENT: TAKE EMERGENCY MEDICATION(S) NAMED BELOW
For cough, wheeze, chest tightness, shortness of breath, cannot do usual activities

_____Medication is located in the clinic (Student go immediately to clinic accompanied by peer or school personnel, if student says he/she is unable to walk to clinic, call for medication to be brought to student)
_____Student carries medication with them at all times with physician and parent approval
_____Student has no medication at school, call parent or EMS/911 if symptoms are severe

EMERGENCY ASTHMA MEDICATIONS :
Name of Bronchodilator (quick-relief medication): _____
Dosage: Take _____ puffs every _____ minutes / hours for up to _____ hours
Name of Other Medication to take during asthmatic episode: _____

****Inhaler may be repeated for severe breathing difficulty _____ times _____ minutes apart.**

MEDICAL ALERT! Call 911/EMS if the student has any of the following:
Coughs constantly
No improvement 15-20 minutes after initial treatment
Peak Flow of _____ or less
Hard time breathing with:
- Chest and neck pulled in with breathing
- Stooped body posture
- Struggling or gasping
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue

***If there is absence of breathing/pulse begin CPR as necessary.**

PHYSICIAN AUTHORIZATION FOR MEDICATION

Doctor's Name_____Address_____ Phone Number_____

☐ I have instructed _____ (student) in the proper way to use his/her inhaler. It is my professional opinion that he/she **SHOULD BE ALLOWED** to carry and self-administer the prescribed medication while at school or school related events.
☐ It is my professional opinion that _____ **SHOULD NOT** be allowed to carry and self-administer his/her inhaler while on school property or school related events.

Physician's Signature:_____ **Date**:_____

I agree to the information and conditions in this Action Plan and understand that a copy of this Action Plan may be given to teachers, school bus drivers, or other school personnel as necessary for the health and safety of my child.

Parent/Guardian's Signature:_____ **Date**:_____