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 & 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 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 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 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.

PHYSICIAN SIGNATURE: _____

DATE: _____

NAME: _____

ADDRESS: _____

_____