This form valid for school year _____

School Asthma Action Plan

PARENT SECTION

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____ School: _____ Grade: _____

Parent/Guardian Name: _____ Parent/Guardian Phone #: _____

I, the undersigned, as legal parent/guardian of the above named student request a designated member of the school staff make available the following listed medication(s) to my child as prescribed on this School Asthma Action Plan

Parent/Guardian Signature: _____ Date: _____

MEDICAL TREATMENT PLAN *(To be completed by Healthcare Provider)*

Asthma symptoms are triggered by: ☐ Exercise ☐ Dust ☐ Animal dander ☐ Strong Odors or Fumes ☐ Mold ☐ _____

GO, Student is doing well!		**Daily Controller Medicines**			
Student has all of these: * Breathing is good * No cough or wheeze * Sleep through the night * Can go to school and play	Peak flow from _____ to _____	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN	WHERE
					☐ Home ☐ School
					☐ Home ☐ School
					☐ Home ☐ School

Exercise Pretreatment Instructions *(check all that apply)*

☐ Give 2 puffs of quick relief inhaler 15 minutes prior to recess/physical education and/or _____.

☐ May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or _____.

☐ Measure Peak Flow prior to recess/physical education; restrict aerobic activity when child's peak flow is below _____.

CAUTION – Slow Down!		**Quick Relief Medicine at School**		
Student has any of these: * Cough * Mild wheeze * Trouble breathing	Peak flow from _____ to _____	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

DANGER – Get Help!		**IF ANY OF THE FOLLOWING ARE HAPPENING, SEEK EMERGENCY CARE:**
CALL **911**	Peak flow from _____ to _____	* Student doesn't feel any better 20-30 minutes after taking quick relief medicines. * Breathing is hard and fast * Nose opens wide * Can't talk well * Lips and fingernails are blue * Unrelieved coughing * Wheezing maybe gone (asthma is so bad that air is not moving) * Very weak and tired

Additional Comments: _____

_____

☐ I have instructed this student in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

☐ In my professional opinion, this student should not carry his/her medication and it should be stored in the health office.

_____ MD/DO/NP/PA _____

Printed Name of Provider Phone

_____ _____

Provider Signature Date