Asthma Action Plan

Date:

Parent to Complete:

Student Name:		DOB:
School:		Grade:
Parent Name:	Mobile Phone:	Work Phone:
Parent Name:	Mobile Phone:	Work Phone:
Emergency Contact:	Relationship:	Phone Number:
Physician Name:	Physician Phone Number:	Physician Fax:

I hereby authorize for the above health care provider's disclosure of health information to the district. I authorize trained school employees, if available, to administer medication to my student and agree to hold the district and its employees harmless from all liability or claims that may arise out of these arrangements. The school is authorized to secure emergency medical services for my child whenever the need for such services are deemed necessary by the principal, school nurse, or designated school staff member. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made.

☐ Yes ☐ No My student may carry and self-administer quick relief medication at school (MD/DO approval required). The principal or designee reserves the right to revoke the priviledge if the student demonstrates irresponsible behavior or incorrect administration. The self-carry privilege is reserved for secondary students (middle and high school) with rare exceptions.

Parent/Guardian Signature _____ Date _____

Education Code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for them by a physician may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

Physician to Complete:

☐ Student is capable and approved to self administer the medication(s) named on this form. They have demonstrated knowledge of the correct dosage and administration and are sufficiently responsible to carry out the directions as instructed.

☐ Student is NOT approved to carry and self-administer the medication(s) named on this form.

Physician Signature _____ Date _____

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Student Last, First

Regular Daily Medication (Taken Outside of School)		
Medicine	**How Much**	**How Often**

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistant ☐ Severe Persistant

Asthma Triggers: ☐ Exercise ☐ Dust ☐ Illness ☐ Weather ☐ Animals ☐ Mold/Moisture ☐ Pollen ☐ Cold ☐ Smoke ☐ Odors ☐ Stress/Emotions ☐ Other:_____

GOOD

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work & play

Medicine	How Much	How Often/When
For asthma with exercise, take:		

CAUTION

You have ANY of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight Chest
- Problems working or playing

Medicine	How Much	How Often/When
Call your Primary Care Provider if in this zone for more than 24 hours		

DANGER

Your asthma is getting worse fast
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well

Medicine	How Much	How Often/When
CALL 911 NOW! DO NOT WAIT. This is a Medical Emergency. Follow up with your primary care provider within two days of an ER visit or hospitalization.		