Stafford Municipal School District Asthma Action Plan

Student Information

Student's name

Grade | School year | Date of birth

Teacher's name

Parent's/Guardian's name

Parent's/Guardian's address

Parent's/Guardian's home phone

Parent's/Guardian's work phone

Emergency contact name

Emergency contact relationship

Emergency contact phone number

Physician student sees for asthma

Physician's phone number

Other physician

Other physician phone number

Self-Administration of Asthma Medications

Bronchodiliator *(quick-relief medication)*

Name of medication

Purpose of medication

Dosage of medication

When to use medication

Can be repeated for severe breathing difficulty

_____ times_____minutes apart.

Call 911 or EMS if minimal or no improvement.

Other medication

Name of medication

Purpose of medication

Dosage of medication

When to use medication

Additional instructions

- I have instructed *(student's name)* _____ in the proper way to use his/her medications. It is my professional opinion that *(student's name)* _____ **should be allowed** to carry and self-administer the following medications while on school property or at school-related events.
- It is my professional opinion that *(student's name)* _____ **should *not* be allowed** to carry and self-administer the following medications while on school property or at school-related events.

Physician's signature | *Date*

I agree with the recommendation of my child's physician as noted and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events.

Parent's signature | *Date*