

School Year

20_____

ELIZABETHTON CITY SCHOOLS**ASTHMA ACTION PLAN**

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To be completed by
Parent/Guardian/School Nurse
Please print

Child Information:

Name: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Emergency Information: Date of Care Plan: _____

Parent/Guardian Names: _____

Mother's Phone #: Cell _____ Work _____

Father's Phone #: Cell _____ Work _____

In the event a Parent/Guardian cannot be reached, please list other adults that may be contacted in the event of an emergency that may pick up your child and/or accompany your child to the Emergency Room if needed.

1. Name: _____ Relation: _____ Telephone: _____

2. Name: _____ Relation: _____ Telephone: _____

Student Medical Information:

Student's Primary Physician: _____ Office #: _____

Address: _____

ALLERGIES: ☐ NO ☐ YES (specify): _____

Triggers that may bring on an asthma attack:

☐ Cigarette Smoke ☐ Exercise ☐ Exposure to Cold Air ☐ Emotional Stress☐ Odors ☐ Other (Please List): _____**Signs/Symptoms** of Asthma Attack most often present in my child (check all that apply):☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Bluish colored skin/nails ☐ Tired☐ Unable to speak without taking a breath ☐ Other (specify): _____My child has the following other **Chronic Conditions:** _____**ALL CURRENT MEDICATIONS**

Name of Medication	Dosage and Strength	Purpose	Time of Day Given

I understand that it is my responsibility to keep this information current and to provide an updated form on at least an annual basis. I agree to maintain an adequate supply of medication at school. I give my permission for school personnel, who volunteer under no duress and are trained by a Registered Nurse, to participate in the care of my child in the event a school nurse is not present. I hereby agree and understand that the Elizabethton City School system and its personnel shall not be held liable for any injury resulting from the reasonable and prudent assistance in the administration of medication/treatment to my child. I give permission for the school nursing staff to share protected healthcare information with other school staff members on a need to know basis.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Staff Members Trained:

Name	Title	Location/Room	Trained By (RN only)

School Year

20____

ELIZABETHTON CITY SCHOOLS

ASTHMA ACTION PLAN

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To be completed by

Physician

Please print

CHILD INFORMATION:

NAME: _____ DATE OF BIRTH: _____

Parent/Guardian Name: _____

Address: _____

MEDICAL DIAGNOSIS: _____

ATTENDING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

ALL CURRENT MEDICATIONS USED FOR ASTHMA (completed by Health Care Provider only):

Name of Medication	Dosage and Strength	Time of Day Given

SPECIAL INSTRUCTIONS/RESTRICTIONS: _____

STUDENT ALLERGIES: _____

For Inhaled Medications (completed by Health Care Provider only):

☐ This child has received instruction in the proper use of his/her inhaled medication. It is my professional opinion that that this student **SHOULD** be allowed to carry and use their prescribed inhaler by him/herself.

☐ It is my professional opinion that this child **SHOULD NOT** be allowed to carry his/her inhaled medication and should use the prescribed inhaler with staff assistance.

Seek emergency medical help if the child:

- Shows **No** improvement within _____ minutes after initial treatment. **May repeat dosage in _____ minutes** if no improvement with 1st dose.
- Struggles for breath or uses accessory muscles in an attempt to breath.
- Blue or gray discoloration of the lips or fingernails

These above signs indicate the need for emergency medical care.

- If in doubt, activate the EMS and call 911.
- Activate the Emergency Response Team in your school.
- Call parent/guardian.

HEALTHCARE PROVIDER SIGNATURE: _____ DATE: _____

I give permission for the Elizabethton City School nursing staff and my child's HealthCare provider to exchange protected healthcare information in order to clarify and/or maintain an Emergency Care Plan for my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL: _____ PHONE: _____

SCHOOL NURSE: _____ FAX: _____