STUDENT RAD/ASTHMA ACTION PLAN – MEDICATION AUTHORIZATION FOR USE OF INHALER – PLEASE FILL OUT BOTH SIDES A & B

Student Name: ______________________________________ School: ______________________

Parent/Guardian #1: Name: ________________________ Home Ph # ____________________

Work Ph #: ____________________ Cell Ph # or Pager #_____________

Parent/Guardian #2: Name: ________________________ Home Ph # ____________________

Work Ph # _____________________ Cell Ph # or Pager # _____________

Emergency Contact: Name: ________________________ Home Ph # ____________________

Work Ph # _____________________ Cell Ph # or Pager # _____________

Physician: Name: _________________________ Office Ph # ____________________

DAILY MANAGEMENT PLAN

Triggers

Identify the things that may start, or trigger, an asthma episode (Circle and/or write in apply that apply):

Exercise

Respiratory Infections

Changes in temperature

Animal fur/dander

Molds

*Insect bites/stings

Strong odors or fumes

Chalk dust

Carpeting

Pollens

*Food: _______________________

* Does student have Epi-Pen? Yes No

Prevention Measures

List any environmental control measure, pre-medication procedure, and/or dietary restriction the student requires to aid in preventing the onset of an asthma episode:

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Daily Medication Plan

Name of Medication	Type (Inhaler, tablet, etc.)	Dosage	When to Use	

______I have instructed the above named student in the proper use of his/her inhaler. It is my professional opinion that he/she be permitted to carry and use the inhaler by him/herself.

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______It is my professional opinion that the above named student should NOT carry his/her inhaler.

Physician Signature______________________________ Date:________________________

Parent Signature_________________________________ Date_________________________

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PLEASE COMPLETE SIDE B

Nurses may need to contact your physician regarding medication ordered for clarification.

EMERGENCY PLAN

Student: ____________________ School: ____________________
Medical Diagnosis: ____________________ Date of Birth: ____________________
Preferred hospital in case of emergency: ____________________
Insurance Company: ____________________ Policy/Group Number: ____________________
Physician: ____________________ Phone #: ____________________

IF YOU SEE THIS…	**DO THIS….**
Complaints of tightness in chest, coughing or wheezing	1.Administer or have student self-administer the following medication(s): Med:____________________ Dose: ______________ Med: ____________________ Dose: ______________ 2. Observe student closely for any change in condition. 3. Allow student to return to class or normal activity if symptoms relieved after using medication.
No change in symptoms within 15 minutes of using medication(s)	1. Repeat medication(s) as listed in Step 1 above 2. Contact parent/guardian to inform him/her student has used medication X2 with little or no improvement
No improvement in symptoms after second dose of meds **and** unable to contact parent/guardian after second dose administered	1. Call 9-1-1 2. Continue to try and contact parent/guardian
Symptoms worsen **or** student is hunched over, difficulty breathing, unable to speak, use of neck and shoulder muscles to assist in breathing effort, lips and/or nail beds blue in color	1. Call 9-1-1 2. Call parent/guardian 3. Remain with student until EMS personnel arrive.
Student becomes unconscious	1. Start CPR 2. Call 9-1-1 3. Call parent/guardian

I DO / DO NOT give permission for my child to be transported by emergency personnel in the event of a severe asthma episode, as described above.

I DO / DO NOT give permission for school personnel to release a copy of this plan/emergency form to emergency personnel in the event it is necessary to transport my child to the hospital.

____________________ ____________________
Parent/Guardian's Signature Date

I authorize school personnel to implement this management and emergency plan as described above.

____________________ ____________________
Physician's Signature Printed Name Date

____________________ ____________________
Parent/Guardian's Signature Date

Nurses may need to contact your physician regarding medication ordered for clarification.