School Year _____

DANVILLE AREA SCHOOL DISTRICT
STUDENT ASTHMA ACTION PLAN

Name: _____ Grade: _____ Age: _____
Homeroom Teacher: _____ Room: _____
Parent/Guardian: Name: _____ Ph (h): _____
Address: _____ Ph (w): _____

Parent/Guardian Name: _____ Ph (h): _____
Address: _____ Ph (w): _____

Emergency Phone Contact: _____
Physician Treating Student for Asthma: _____

DAILY ASTHAMA MANANGEMENT PLAN

- **Identify the things which start an asthma episode (Check each that applies to the student).**

ڤ Exercise
ڤ Respiratory infections
ڤ Change in temperature
ڤ Animals
ڤ Food
ڤ Strong odors or fumes
ڤ Chalk dust/ dust
ڤ Carpets in the room
ڤ Pollens
ڤ Molds
ڤ Other _____
_____
_____

Comments _____

- **Control of School Environment**

(list any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode). _____
_____

- **Peak Flow Monitoring**

Personal Best Peak Flow Number: _____
Monitoring times: _____ _____ _____ _____

- **Daily Medication Plan**

	Name	Amount	When to use
1.			
2.			
3.			
4.			

EMERGENCY/RESCUE MEDICATION PLAN

	Name	Amount	When to Use
1.			
2.			
3.			

COMMENTS/SPECIAL INSTRUCTIONS

_____

_____

Physician's Signature: _____ **Date:** _____

School Year _____

SELF ADMINISTRATION OF ASTHMA MEDICATIONS

A Student Asthma Action Plan <u>MUST</u> accompany this form

Name _____ **Grade** _____

To self medicate, the student must be able to: (please check)

____ 1. Respond to and visually recognize his/her name.
____ 2. Identify his/her medication.
_____ 3. Demonstrate the proper technique for self-administering his/her medication.
_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.
_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of medication	**Dose**	**Frequency**

PARENT PERMISSION

As the parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medications(s) when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature

PHYSICIAN PERMISSION (check one)

ڤ I have instructed the student in the proper way to use his/her medications. It is my professional opinion that this student **SHOULD** be allowed to carry and use his/her inhaled medication(s) by him/herself.

ڤ It is my professional opinion that this student **SHOULD NOT** be allowed to carry and use his/her inhaled medication(s) by him/herself.

_____ _____

Date Physician's signature

_____ _____

Printed physician's name Physician's phone number

STUDENT COMMITMENT

I agree to be solely responsible for my asthma inhaler, to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler. I agree to notify the school nurse immediately following each use of my asthma inhaler.

_____ _____

Date Student's signature