Petal School District
Asthma Action Plan

Name:_____ Date:_____

PARENT/GUARDIAN SECTION:

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*The school nurse or principal's designee has my permission to administer medication to my child as ordered by Dr. _____ . I understand that this Asthma Action Plan is only good for the current school year. I consent to the exchange of information between the physician/nurse practitioner and the school nurse regarding this medication and treatment. **In the event of self administration of asthma medication, the parent releases the school district and its employees from liability for an injury arising from the student's self administration of the prescription medication while on school property or school-related activities.***

_____
Parent/guardian signature

PHYSICIAN SECTION:

Instructions for School Personnel:

1. **If coughing or wheezing, give:**
   - ☐ Albuterol Inhaler: 2-4 puffs with/without spacer
   - ☐ Albuterol Nebulizer: 1 treatment vial

2. **Administration: *(pick one)***
   - ☐ Student is responsible to self carry and self administer ALL asthma medications
   - ☐ School Nurse/personnel administers ALL asthma medications and notify parent/guardian

3. **Pre-Medication before Exercise: *(pick one)***
   - ☐ No – The student does *not* require albuterol before exercise.
   - ☐ Yes – The student requires albuterol _____ puffs 15-30 minutes before exercise daily.

4. **Other instructions:**

_____

_____

Physician Signature: _____

Physician Name (print): _____

Clinic and Phone Number:_____