pennsylvania
DEPARTMENT OF HEALTH

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

PHILADELPHIA ALLIES AGAINST ASTHMA
Giving Children Freedom to Breathe

Name _____ Age _____

School _____ Parent/Guardian _____ Parent's Phone _____

Doctor/Nurse's Name _____ Doctor/Nurse's Office Phone _____

Emergency Contact After Parent _____ Contact Phone _____

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other: _____

TAKE THESE MEDICINES EVERYDAY

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXEXCISE USE THIS MEDICINE:

IF NOT FEELING WELL — TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

Child has *any* of these:

- Cough
- Wheeze
- Tight Chest

Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! — TAKE THESE MEDICINES

Child has *any* of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

Peak flow below:

_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature _____ Date _____

Health Care Provider Signature _____

☐ **It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the NYC Childhood Asthma Initiative

Adapted forms the NHLBI

Revised 2013

NORTHERN YORK COUNTY SCHOOL DISTRICT
SELF-ADMINISTRATION OF ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR PERMISSION FORM

Name _____ Name of Medication _____ Date _____

School _____ Grade _____ DOB _____

Criterion for student self-administration of Asthma Inhaler and/or Epinephrine Auto-Injector

The prescribed medication shall be maintained in a clearly labeled original container noting the child's name, the medication name, and the time and/or special circumstances for self-administration.

Student is able to:

-Verbalize symptoms/situation related to the need for medication use.
-Demonstrate the correct technique for self-administration of the medication.
-Follow the emergency action plan as prescribed by physician.
-Inform the school nurse immediately after self-administering asthma inhaler or epinephrine auto-injector.
-Store medication in a secure location where it is easily accessible.

I have received instruction from my prescriber on proper safety precautions for the handling and disposal of the asthma inhaler and/or epinephrine auto injector. I will take responsibility for carrying and self-administration of my asthma inhaler and/or epinephrine auto-injector at school. I have read and understand the school policy regarding self-administration and possession of this medication. If I violate this school policy, I understand that it will result in loss of privilege to self-carry my medication as well as possible disciplinary action in accordance with Board policy. **I understand that in order for me to self-administer and carry my medication, I must meet with the school nurse for final approval of this process.**

STUDENT SIGNATURE _____ Date _____

I certify that my son/daughter is able and responsible to carry and self-administer their asthma inhaler and/or epinephrine auto-injector. I give permission for self-administration and possession of the ordered medication for my child to use during school hours, at any time while on school property, at any school-sponsored activity, and during the time spent traveling to and from school and school-sponsored activities. I understand and consent to the stipulations of the school policy regarding self-administration of medication. I understand my child may lose this privilege if the policy is violated. I understand and agree that in the event of an emergency, a district employee may administer emergency medication (e.g epinephrine, inhalers, etc.) when s/he believes, in good faith, that a student needs emergency care. I also agree that the school entity bears no responsibility for ensuring that the medication is taken. I understand that emergency medical services will always be notified when epinephrine is administered, whether or not the student manifests any symptoms of anaphylaxis. I will inform the school nurse if there are changes in this medication.

I hereby release, indemnify, and hold harmless the Northern York County School District, its employees, and its agents against any claim(s) arising out of the administration or self-administration of medication pursuant to this permission form, or related to the benefits or consequences of the prescribed medication. **I understand this permission form must be completed by both a physician and the school nurse prior to my child self-administering or carrying his/her emergency medication.**

PARENT/GUARDIAN SIGNATURE _____ Date _____

It is my professional opinion that this student may carry and self-administer his/her medication according to the orders prescribed on the attached emergency action plan.

PHYSICIAN SIGNATURE _____Date _____

The student, _____has demonstrated competency for self-administration and responsible behavior in use of the prescribed medication.

SCHOOL NURSE SIGNATURE _____ Date _____

This authorization is good for one school year and must be renewed each year.