## **ASTHMA ACTION PLAN**

STUDENT NAME: GRADE:	BIRTHDATE:///			
Emergency action is necessary when student:	TEACHER			
☐ Has symptoms such as:				
☐ Has a peak flow reading of:				
Other, please describe:				
STEPS TO TAKE DURING AN ASTHMA EPISODE:				
☐ Give rescue inhaler	,puffs.			
Contact parent if no improvement in 15-20 minutes.				
☐ Other:				
Student may return to class, if:				
SEEK EMERGENCY CARE IF:				
If the student has any of the following, please seek er  - If no improvement is seen within 15-20 minutes after be reached.  - Peak Flow Reading of:  - Hard time breathing  - Struggling to breathe  - Hunched over  - Chest retracting  - Difficulty walking or talking  - Lips or fingertips are gray or blue  SEEK EMERGENCY CARE!				
EMERGENCY MEDICATION				
Medication Name: Dose/Ai	TOUNT: When to use:			
COMMENTS/SPECIAL INSTRUCTIONS				
COMPETENCE USING INHALED MEDICATION				
has been instructed and demonstrates the proper use of inhaled medication.				
☐ It is my opinion that he/she should be allowed to carry and use the medication by him/herself.				
It is my opinion that he/she should NOT carry and use the medication by him/herself.				
Parent and phys	ician;			
Please complete, sign, and date the reverse side of this form				



## Prescribed Medication Authorization

A new form must be completed for each dosage/med	,	•	
Name			
School	Teacher	Grade	Room
To the Parent/Guardian:			
THE FOLLOWING INFORMATION IS NECESSARY FOR OF THISMUST BE COMPLETE.	ANY STUDENT WHO RECEIVES OR USE	S PRESCRIBED MEDICATION	NS IN SCHOOL; BOTH PORTIONS
<ol> <li>I am requesting permission for the verification on this form. I have inst designated time. I will keep an aded</li> <li>I will assume responsibility for safe to make other arrangements.</li> <li>I will call the school office and send within three (3) days. I understand</li> <li>I will bring in a completed prescribe</li> <li>I release and agree to hold the Boo or injury resulting directly or indirections</li> </ol>	ructed my child to report to the quate supply of medication at sol delivery of the medication to the a written note if my child is take the medication may be disposed and its officials, and its employee	school office to receive hool. e school office either by en off this medication. I d of after three days. n for any dosage/med	e the medication at the myself or call the principal will retrieve the medication ication/doctor changes.
Parent/Guardian Signature	Today	y's Date	
Parent/Guardian Printed Name			
Home Phone		< Phone	
ALL MEDICATION MUST BE IN ORIGINAL PHARMAI  To the Physician:	CY DISPENSED CONTAINERS. LABELS N		S FROM DOCTOR ON THIS FORM.
The Board urges you to schedule the taking possible, the receiving or using of medication form is preferable to liquids for use in school to the school of t	ns will be permitted, insofar as f	imes outside of school feasible, during school	hours. When that is not hours. Medication in pill
I verify that this medication must be taken b	Name of Student		
Medication	Dosage		Route
Diagnosis for which medication is prescribe	d		
Medication is to be taken at the following tir	nes		
Instructions or precautions (Including possible s			
Adverse reactions that need to be reported			
Prescription beginning date	Prescription expire	ation date	
Date form completed	_Physician Signature		
Physician Printed Name	Phon	e#	
Physician Address			