

Asthma Action Plan

School Year _____

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Healthcare Provider Name(s):	Phone:	

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

Life-Threatening Allergy ☐ Yes* ☐ No * Allergy to: _____

GO Use these daily controller medicines:			
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
You have all of these: • Breathing is good • No cough or wheeze • Can work & play			
	Medication recommended prior to physical activity:		

CAUTION Continue with green zone medicine and add:			
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
You have all of these: • First signs of a cold • Exposure to known trigger • Cough • Mild wheeze • Tight chest			

RED ZONE MEDICINES ARE NOW ADMINISTERED TO YOU			
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Your asthma is getting worse fast: • Medicine is not helping • Breathing is hard & fast • Nose opens wide • Trouble speaking			

(PRINTED NAME OF PHYSICIAN)

(SIGNATURE OF PHYSICIAN / DATE)

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian Signature

Date:

Dear Parent,

You stated that your child has asthma. The law requires we have a doctor's signature and authorization for the following:

1) If a student requires an inhaler/meds to be at school, we must have:

- An Asthma Action Plan completed and signed by the doctor

2) If a student **Does Not** bring an inhaler/asthma meds to school but uses them at home, we must have:

- An Asthma Action Plan completed and signed by the doctor

3) If a student is not currently under the care of a doctor and takes no medication for asthma:

- If your child has Asthma, but is not currently under the care of a doctor for their Asthma & requires no medicine for Asthma, please check the statement below & sign where indicated.

____ My child, _____, is not currently under the care of a doctor for Asthma & is currently taking no medication for Asthma. I acknowledge being informed of the Asthma Law. If my child's health status changes & a diagnosis of Asthma/if treatment is started, I understand that I am required to provide the school with the above information.

Date: _____

Parent/Guardian: _____

AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER PRESCRIPTION ASTHMA AND/OR ANAPHYLAXIS MEDICATION

 *Action Plans are required by law for students diagnosed with Asthma and/or Anaphylaxis Conditions* 

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

Diagnosis: _____

Medication / Purpose: _____

Prescribed Dose: _____

TIME: (The times at which or circumstances under which medication may be administered): _____

HEALTH CARE PROVIDER STATEMENT

The student has asthma and/or anaphylaxis and is capable of self-administering the prescription asthma and or anaphylaxis medication. I recommend the student be allowed to carry prescription medication as prescribed.

 **Provider's Signature/DATE** _____

 **Printed Provider Name** _____

Telephone: _____

Fax: _____

***** PARENT/GUARDIAN SECTION*****

PARENT/GUARDIAN AUTHORIZATION

I authorize my child/student to carry and self-administer prescription asthma and/or anaphylaxis medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

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 **Parent/Guardian Signature/DATE** _____

 **Printed Name** _____

Emergency contact phone number: _____



Life-Threatening Allergy Action Plan

School Year _____

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Physician / Healthcare Provider	Phone:	

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

ALLERGY TO:

Asthmatic ☐ Yes* ☐ No * Higher risk for severe reaction

STEP 1: TREATMENT

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

SYMPTOMS:

- If a food allergen has been ingested, but no symptoms
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† _____
- If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change. †Potentially life-threatening.

GIVE CHECKED MEDICATION

- | | |
|--------------------------------------|--|
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |
| ☐ Epinephrine | ☐ Antihistamine |

MEDICATION DOSAGE & ROUTE

Antihistamine:

Dose: _____

Epinephrine:

Inject epinephrine in thigh using (check one):

- | | |
|--|---|
| ☐ Adrenaclick (0.15 mg) | ☐ Adrenaclick (0.3 mg) |
| ☐ EpiPen Jr (0.15 mg) | ☐ EpiPen (0.3 mg) |
| Epinephrine Injection, USP Auto-injector- authorized generic | |
| ☐ (0.15 mg) | ☐ (0.3 mg) |
| ☐ Other (0.15 mg) | ☐ Other (0.3 mg) |

Other: _____

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

(PRINTED NAME OF PHYSICIAN)

(SIGNATURE OF PHYSICIAN / DATE)

STEP 2: EMERGENCY CALLS

911 CALL REQUIRED UPON EPI-PEN DELIVERY.

NOTIFY Parent/Guardian of all allergic reactions and treatment.

① Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

② Emergency Contact Person:

Contact Phone(s):

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Parent/Guardian Signature _____

DATE _____