BISMARCK PUBLIC SCHOOLS

BPS Student Asthma Action Plan and Authorization for Reliever Medication

Child's Name	**DOB**	**Grade**
Parent(s)/Guardian(s)	**School/Teacher**	
Parent/Guardian Phone Numbers: Home:	**Work:**	**Cell:**
Emergency Contact (Other Than Parent/Guardian)	**Emergency Phone**	
Physician/Phone	**Hospital/Phone**	

ASTHMA MANAGEMENT INFORMATION

1. Reliever inhaler to treat symptoms:

Name of medication _____ Dose/Frequency _____

Will child have inhaler at school? _____

Where will inhaler be stored (office/backpack/etc.) _____

2. Identify what triggers an asthma episode (*check all that apply*):

☐ Exercise	☐ Strong odors or fumes	☐ Molds/Pollens
☐ Respiratory infections	☐ Tobacco smoke	☐ Change in temperature
☐ Animals:_____	☐ Foods: _____	☐ Other:_____

3. Identify how to prevent an asthma episode (ex: environmental controls, dietary restrictions, etc):

_____

4. When was this child diagnosed with asthma:_____

5. When was this child's last clinic or hospital visit for asthma:_____

6. Daily asthma or allergy medications taken at home

	Name	Dosage/times usually given
a.	_____	_____
b.	_____	_____

7. Is peak flow monitoring done by this child? ☐ Yes ☐ No

Personal best peak flow number:_____ Monitoring times:_____ _____ _____

PLAN OF CARE

If your child appears to have asthma symptoms, school staff will do the following:

1. Assist the child to locate their inhaler if it is at school or call the parent if it is not at school.
2. Assist the child to use their inhaler as directed in Section F.
3. Allow the child to return to class/regular activity if his/her symptoms are relieved.
4. Call an ambulance if the child has the following symptoms not relieved by the inhaler:
   - Difficulty breathing: hunched over, struggling to breathe, gasping, chest & neck retracted
   - Lips or fingernails are gray or blue.

(**Continued on Back Side)**

PARENT CARE AUTHORIZATION

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to School personnel to contact my child's physician as needed; and that education/health information may be shared with staff who need to know.

Parent/Guardian Signature of Approval (*Required*):_____ Date:_____

MEDICATION AUTHORIZATION

Fill out this section if BPS staff will assist your child in administration of his/her inhaler medication:

- **I give permission to Bismarck Public School personnel to store and administer my child's reliever inhaler;** *I also acknowledge that school personnel will not be held legally or financially responsible for the administration of this medication*.

Parent/Guardian Signature of Approval (*Required*):_____ Date:_____

Fill out this section if your child will keep his/her inhaler with them & self-administer the medication:

- **I give consent for Bismarck Public Schools to contact my child's healthcare provider** and have them complete and sign the Provider Section (bottom of page)

I request permission for and authorize my child to self-administer this reliever inhaler during school hours and district-sponsored activities. I also acknowledge and understand the following: School personnel will not be legally or financially responsible for the administration of this medication and may not monitor my child's failure to self-administer it. My child and I shall be solely responsible to ensure the medication is taken as prescribed. In exchange for granting my request to permit my child to self-administer this medication, I agree: (1) To indemnify, defend and hold harmless the Bismarck Public School District, its officers, employees and all other individuals working in their official capacities on behalf of the District from any claim or liability for injuries or damages resulting from the self-administration of the above-named medication; and (2) To acknowledge that I will not seek any recovery from the District for any claim or liability for injury or damages, including without limitation reasonable attorneys' fees and costs, caused or claimed to be caused by the self-administration of the above-described medication.

Parent/Guardian Signature of Approval (*Required*):_____ Date:_____

PROVIDER SECTION (To Be Completed By Health Care Provider)

Student's Name	**Student's DOB**
Prescribing Health Care Provider (print)	**Physician Phone Number**

Medication Administration Options (Check #1 or #2):

1. ☐ **The *school* needs to administer, or help this child administer this reliever medication; or**
2. ☐ **This *child* has received instruction in *self-administration* and is able to safely use and store this reliever medication.**

↳ **Physician or Health Care Provider Approval: ☐ Yes ☐ No**

↳ **Physician or Health Care Provider Signature (REQUIRED):**_____