

Asthma Action Plan Instructions

- Please read and discuss Lakeside’s medication policy, including self-carry and self-administration expectations, with our student. [family handbook linked here]
- All medications (prescription and over-the-counter) given at school or school-sponsored events require **written authorization from a parent/guardian and a licensed healthcare provider.**
- Lakeside follows Washington State safety standards for students with life-threatening conditions (RCW 28A.210.320). Emergency medications must be carried by the student or provided to the school nurse before the first day of school. Students may be excluded until required documentation and medication are received; families will be notified prior to exclusion.
- An Action Plan authorizes the school nurse to provide care during school hours, Washington-based field trips, and summer programs. Extended trips or activities outside school hours may require additional planning, and families are responsible for medication access during those times.
- Medications must be in the **original container** and labeled with the **student’s name, medication name/strength, dosage, timing, and duration.**

Students requiring only asthma medications must complete an Asthma Action Plan. Students who require additional prescription or over-the-counter medications (e.g., prescription or over-the-counter drugs) must also complete the “Medication at Lakeside School” form.

An authorized medication form must be completed and on file at the student’s school, before medication can be stored or administered.

UPPER SCHOOL STUDENTS	MIDDLE SCHOOL STUDENTS
<p>ATTN: Joy Irvin, All-School Nurse PHONE: (206)440-2906 FAX: (206)360-5092 EMAIL: nurse@lakesideschool.org</p> <p>Lakeside School ADDRESS: 14050 1st Ave NE, Seattle, WA 98125</p>	<p>ATTN: Alexis Mee, Middle School & After-School Nurse PHONE: (206)440-2924 FAX: (206)360-5092 EMAIL: nurse@lakesideschool.org</p> <p>Lakeside Middle School ADDRESS: 13510 1st Ave NE, Seattle, WA 98125</p>

Asthma Action Plan (2026-2027 School Year)

Student Name _____		
Date of Birth _____		Grade _____
Valid for: <input type="checkbox"/> 2026-2027 school year, covering June 8, 2026, through August 31st, 2027 <input type="checkbox"/> Other dates: _____		
Triggers: <input type="checkbox"/> Exercise <input type="checkbox"/> Strong odors or fumes <input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Chalk dust / dust <input type="checkbox"/> Change in temperature <input type="checkbox"/> Carpets in the room <input type="checkbox"/> Animals	<input type="checkbox"/> Pollens <input type="checkbox"/> Food <input type="checkbox"/> Molds <input type="checkbox"/> Other: _____

See the attached chart from the ALA (page 3) for when to give the following medications

MEDICATION	DOSAGE (in mcg) and PUFFS	TIME GIVEN/FREQUENCY	ROUTE
Rescue inhaler: <input type="checkbox"/> albuterol (ProAir, Proventil, Ventolin) <input type="checkbox"/> levalbuterol (Xopenex) <input type="checkbox"/> budesonide/formoterol (Symbicort) <input type="checkbox"/> mometasone/formotero (Dulera)	_____mcg _____puffs		Inhaled
Long-acting/daily inhaler (if different than above)	_____mcg _____puffs		Inhaled

Parent/Guardian Authorization:	Healthcare Provider Authorization:
<input type="checkbox"/> STORE IN HEALTH ROOM ONLY: I request that authorized persons at my school assist my child in taking medicine described below. <input type="checkbox"/> SELF-CARRY IN BAG / ON PERSON: I request that my child be allowed to self-carry and self-administer medication <u>OR</u> I am 18 years or older and am signing this form on my own behalf.	<input type="checkbox"/> YES – self-carry & self-administer: I have instructed this student in proper medication use. They may carry and self-administer, unless medically unable. An authorized adult will provide support if needed. <input type="checkbox"/> NO – store in health room only: Medication should be stored safely for quick access, not carried by student.

Additionally, I/We authorize communication between the school nurse and my/our child's healthcare provider below as necessary to support the safe management of medication at school.

Parent/Guardian Signature (or Self if 18+): Date: _____ Print Name: _____	Licensed Healthcare Provider Signature: Date: _____ Print Name: _____
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Green zone: Doing well

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Yellow zone: Getting worse

- Some problems breathing
- Cough, wheeze or tight chest
- Problems working or playing
- Wake at night

Red zone: Medical alert

Contact 911 immediately for the following symptoms:

- Lots of problems breathing
 - o Struggling or gasping
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Chest and neck pulled in with breathing
- Stooped body posture

Adapted from American Lung Association