Asthma Medication and Action Plan

Revised 2026

This form is valid for the current school year: 20_____ - 20_____

Student Information

Student Name: _____ Date of Birth: _____ Student ID#: _____

Grade: _____ HR Teacher: _____ Diagnosis: _____

Asthma Triggers

Check all that apply:

- ☐ Pollen
- ☐ Mold
- ☐ Carpet
- ☐ Pets/Animals
- ☐ Foods
- ☐ Exercise
- ☐ Cold air
- ☐ Ozone
- ☐ Respiratory Infections (e.g., cold, flu)
- ☐ Smoke
- ☐ Pollution
- ☐ Perfumes/fragrances
- ☐ Stress/Anxiety
- ☐ Other: _____

Physical Education/Recess Plan

Select only ONE of the choices below regarding the student's physical activity and asthma plan:

☐ Attempt PE/Recess participation normally. If sign/symptoms occur, stop activity and call for nurse.

OR

☐ Use inhaler _____ minutes before exercise/activity, then participate normally.

Select any additions to the above physical activity plan:

- ☐ Not to participate in extensive running or jumping but may walk or do other non-exertive activity instead.
- ☐ Not to participate in physical activity at PE/Recess during periods of exacerbation or illness.
- ☐ Other modifications or precautions: _____

Emergency Plan

Symptoms requiring immediate action:

- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Oxygen saturation below _____
- ☐ Nasal flaring
- ☐ Student is hunched over
- ☐ Trouble talking/walking
- ☐ Lips or fingernails are gray/blue
- ☐ Chest and neck pulls in when breathing

Action Steps:

1. Call for school nurse at onset of symptoms for assessment and treatment.
2. Contact parent/guardian depending on severity.
3. If symptoms do not improve in 20 minutes after initial treatment of medication and parent/guardian cannot be reached, **CALL 911.**

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Medication Information

	Metered Dose Inhaler (with spacer)	**Nebulizer Treatment** (if applicable)
Medication Name	☐ Rescue ☐ Controller	
Dosage		
Administration Time		
Frequency		
May Repeat	_____ times in _____ minute intervals	_____ times in _____ minute intervals

Authorization

Physician Authorization:

I authorize the administration of the above-named medications/treatments to this student during school hours.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ Physician Phone: _____

Parent/Guardian Authorization:

My signature below indicates that I request GPISD staff or contracted outside agency staff to administer the medications/treatments specified above to my child, and I am giving permission for GPISD staff or contracted outside agency staff to contact the physician for additional information, if needed. *Mi firma a continuación indica que solicito al personal de PISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal PISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

- ☐ I have provided the school with the correct medication/dosage in its original container.
- ☐ I understand a new form is needed for all changes in medication, dose, or time.
- ☐ I understand all medication shall be brought to the school by a parent/guardian or responsible adult.
- ☐ Unless otherwise specified, this order is valid for the entire school year including summer session if applicable.
- ☐ Expired and discontinued medication not picked up by the last day of school will be destroyed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____

Medication Inventory Record

Date	Amount Received (count with parent/adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication	Expiration Date

Date	Amount Returned	Signature of Person Medication Returned to	Signature of School Employee Receiving Medication	Comments