Asthma Medication & Self-Management 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: _____

Medication Information

	Metered Dose Inhaler #1		**Metered Dose Inhaler** #2
Medication Name		☐ Rescue ☐ Controller	
Dosage			
Administration Time			
Frequency			
May Repeat	_____ times in _____ minute intervals		_____ times in _____ minute intervals

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Authorization

Physician Authorization:

- ☐ This student has received instructions and is capable of identifying signs, symptoms, and need of asthma medication.
- ☐ This student has been trained and has demonstrated to me the proper administration technique.
- ☐ This student understands correct dosage and times of administration and knows to inform a responsible adult if there is no relief or if condition worsens after administration of the medication.
- ☐ I understand that the student must also demonstrate to the school nurse the necessary skill level to be allowed to carry and self-administer their medication during school hours.
- ☐ It is my professional opinion that this student is capable of self-administering the prescription asthma medication(s) and **SHOULD** be allowed to carry and self-use the medications listed on this form.
- ☐ It is my professional opinion that this student **is not** capable of self-administering the prescription asthma medication(s) and **SHOULD NOT** be allowed to carry and self-use the medications listed on this form.

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 medication 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 GPISD 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 GPISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

- ☐ I have submitted the form ***Parent's Request for Administering Prescription Medicine at School*** to be used in the event my child is unable to self-administer their asthma medication.
- ☐ I request that my child, named above, be allowed to carry and use his/her prescription asthma medication as needed.
- ☐ I understand that it is recommended that backup medication be stored with the school nurse in case my child forgets or loses their medication. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and the student is without medication when it is needed.
- ☐ I have instructed my child to alert a responsible adult if the asthma symptoms are not relieved or worsen after self- administration of the asthma medication.
- ☐ I have instructed my child to alert a responsible adult if the asthma symptoms are not relieved or worsen after self- administration of the asthma medication.

Parent/Guardian Signature: _____ Date: _____

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