

Butler Area School District
Asthma Action Plan

School Year ____/____

Must be completed each school year

Student Name: _____ Birth Date: _____ Grade: _____ Room: _____

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather

Other: _____

Please circle all asthma related answers to show child's condition over the last year.

- School days missed: none _____ 1-3 _____ more than 5 _____
- Emergency room visits: none _____ 1-3 _____ more than 5 _____
- Hospital admissions: none _____ 1-3 _____ more than 3 _____
- Student has medication (inhaler/nebulizer) at school? Yes _____ No _____

Early warning signs (check all the apply)

____ wheeze ____ cough ____ chest tightness
____ pain in chest ____ pain in back ____ short of breath
____ difficulty breathing ____ little energy to play ____ other (_____)

Medications

Take at home	Dose	Route	Frequency
Take at school	Dose	Route	Frequency

Side Effects: _____

20 minutes before exercise, this medication should be used.

Medication	Dose	Route	Frequency

****Please notify school nurse when your student required medication before school due to asthma symptoms.****

I, the Parent/Guardian, do hereby release, discharge, and hold harmless the Butler Area School District, its agents and employees, from any and all liability, and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

I give my permission for the school nurse to use the information provided to share with Butler Area School District personnel and for the nurse to contact my child's asthma physician listed below to discuss my child's conditions as needed.

I give permission for the fax transmittal of this form between School Nurse and Physician Office.

Parent/Guardian signature: _____ Date: _____

Home Phone: _____ Work Phone: _____

Both Parental and Physician Authorizations must be received before medication can be administered.

Physician's signature: _____ Date: _____

Printed Name: _____ Phone Number: _____