ASTHMA ACTION PLAN FOR SCHOOL

Student's Name_____School_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise**

allergy (please specify)_____ other_____

Current medications for asthma control:_____

_____

Asthma medication to be given at school:_____

_____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: A school district may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs at school, follow these steps:

1._____

2._____

3._____

4._____

Other special instructions: _____

Date:_____**Health Care Provider Signature**:_____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

✍✍ if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.

✍✍ if my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the health office, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.

✍✍ if I am not available at numbers listed on reverse side, contact:

Name _____Phone number_____

Additional Comments:_____

_____

Parent/Guardian Signature_____**Date**_____

TO BE COMPLETED BY SCHOOL

Date received at school_____

Nurse Signature_____ **Principal Signature**_____