# ASTHMA ACTION PLAN

*Student Photo*

## Student Information:

Student: _____ Birthdate: _____

School: _____ Grade/Rm. _____

## Emergency Information:

Parent(s) or Guardian(s) _____

**Mother:** Tel (W) _____ Tel (H) _____

**Father:** Tel (W) _____ Tel (H) _____

**Healthcare Provider** _____ Tel_____

In case of emergency, contact:

1. Name _____ Tel_____
2. Name _____ Tel_____

## Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: _____

| Name of Medication | Dosage | Time |
|---|---|---|
| | | |
| | | |

Start Date _____End Date _____

## Steps for an Acute Asthma Episode (to be completed by physician)

1. _____

2. _____

3. _____

4. _____

**Signature of Parent/Guardian_____ Date_____**

**Signature of Prescriber _____Date_____**

## PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER

# **********SELF-MEDICATION FOR ASTHMA INHALERS**********
# Authorization
## (In accordance with ORC 3313.716/3313.14)

☐ **Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF- MEDICATE at school.**

**Complete the following and parent/guardian and healthcare provider must SIGN below:**

Student Name_____

Medication _____

Dosage/Time(frequency) _____

Date to Begin Administration _____

Date to End Administration _____

Adverse reactions that should be reported to physician:

Adverse reactions for unauthorized user:

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

Other special instructions:

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## Prescriber and Parent/Guardian Names and Signatures REQUIRED for Self Medication of Asthma Inhalers:

Prescriber Name _____ Tel_____

Signature of Prescriber _____ Date _____

Parent/Guardian Name(s) _____ Tel_____

Signature of Parent/Guardian _____ Date _____

**Copies must be provided to the principal and to the nurse.**