ASTHMA ACTION PLAN

STUDENT NAME: ______________________ **BIRTHDATE:** _____/_____/______
SCHOOL YEAR: ________-________ **GRADE:** ____ **TEACHER:**_______________

Emergency action is necessary when student:

☐ Has symptoms such as: ____

☐ Has a peak flow reading of: _____________

☐ Other, please describe: ____

STEPS TO TAKE DURING AN ASTHMA EPISODE:

☐ Give rescue inhaler ___________________________, _________puffs.

☐ Contact parent if no improvement in 15-20 minutes.

☐ Other: ____

☐ Student may return to class, if: ____

SEEK EMERGENCY CARE IF:

If the student has any of the following, please seek emergency medical care:

- If no improvement is seen within15-20 minutes after initial treatment and a parent/guardian cannot be reached.
- Peak Flow Reading of: ___________
- Hard time breathing
- Struggling to breathe
- Hunched over
- Chest retracting
- Difficulty walking or talking
- Lips or fingertips are gray or blue

SEEK EMERGENCY CARE!

EMERGENCY MEDICATION

Medication Name:	Dose/Amount:	When to use:

COMMENTS/SPECIAL INSTRUCTIONS

____

____

COMPETENCE USING INHALED MEDICATION

____________________ has been instructed and demonstrates the proper use of inhaled medication.
Name of Student

☐ It is my opinion that he/she should be allowed to carry and use the medication by him/herself.

☐ It is my opinion that he/she should NOT carry and use the medication by him/herself.

Parent and physician;
Please complete, sign, and date the reverse side of this form

5330 F1

Prescribed Medication Authorization

A new form must be completed for each dosage/medication/doctor change. Each school year a new form must be completed for each medication.

Name ______________________ Address ______________________ Birth Date ______________

School ______________________ Teacher ______________ Grade __________ Room __________

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO RECEIVES OR USES PRESCRIBED MEDICATIONS IN SCHOOL; BOTH PORTIONS OF THIS MUST BE COMPLETE.

1. I am requesting permission for the student named above to receive or use medication according to the doctor's verification on this form. I have instructed my child to report to the school office to receive the medication at the designated time. I will keep an adequate supply of medication at school.
2. I will assume responsibility for safe delivery of the medication to the school office either by myself or call the principal to make other arrangements.
3. I will call the school office and send a written note if my child is taken off this medication. I will retrieve the medication within three (3) days. I understand the medication may be disposed of after three days.
4. I will bring in a completed prescribed medication authorization form for any dosage/medication/doctor changes.
5. I release and agree to hold the Board, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

______________________ Parent/Guardian Signature

______________________ Today's Date

______________________ Parent/Guardian Printed Name

______________________ Home Phone

______________________ Work Phone

ALL MEDICATION MUST BE IN ORIGINAL PHARMACY DISPENSED CONTAINERS. LABELS MUST MATCH INSTRUCTIONS FROM DOCTOR ON THIS FORM.

PHYSICIAN'S STATEMENT

To the Physician:

The Board urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving or using of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by ______________________
Name of Student

______________________ Medication ______________________ Dosage ______________ Route

Diagnosis for which medication is prescribed ______________________

Medication is to be taken at the following times ______________________

Instructions or precautions (Including possible side effects) ______________________

____

Adverse reactions that need to be reported to the physician ______________________

Prescription beginning date ______________ Prescription expiration date ______________

Date form completed ______________ Physician Signature ______________________

Physician Printed Name ______________________ Phone # ______________

Physician Address ______________________

Recommended by Central Ohio Association of Nurses