Asthma Action Plan

Student _____ Grade/Homeroom _____

D. O. B. _____ Phys. Ed. days/times _____

Emergency Information

Parent(s)/Guardian(s) _____

Mother: Father:

Home phone _____ Home phone _____

Work phone _____ Work phone _____

Physician _____ Telephone _____

In case of emergency, contact:

1. _____

2. _____

3. _____

Triggers: _____

Personal best peak flow: _____

All current Medications:

Name of medication	Dosage	Frequency / Time

Medications to be Given at School (if any)

Name of medication	Dosage	Frequency / Time

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

1. _____

2. _____

3. _____

4. _____

Parent's/Guardian's signature _____ Date _____

Physician's signature _____ Date _____

Wyomissing Area School District

Asthma Inhalers

Self-Administration by Students

Student's Name _____ Grade _____ Date _____

To self-medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self-administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication, or contact school nurse after self-medicating.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of medication _____

Dosage _____ Frequency _____

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

_____ _____

Date Signature (Parent / Physician / Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication may result in discipline, as determined by the school principal.

_____ _____

Date Signature (Parent / Guardian)

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any improper use/sharing of the above named medication may result in discipline, as determined by the school principal.

_____ _____

Date Signature (Student)