Asthma Action Plan

Polk County Schools – Date of Plan _____

Copies To:
Date: _____
Principal_____
Teacher _____
PE _____
Music_____
Art_____
Library_____
Cafeteria____ Bus___
Bus #

NAME OF STUDENT_____ Birthday: _____

Parent/Guardian _____Telephone_____

Emergency Contact #1_____Telephone_____

Emergency Contact #2_____Telephone_____

Diagnosis: Asthma **Requires inhaler at school**? Yes☐ No☐

Asthma Medications at School **Medicine to be kept in _____**

Medication/Inhaler	**Amount**	**Directions for Medicine Use**

If inhaler is used to correct asthma and symptoms are NOT relieved in 15 minutes …

____ CALL Parent
____ Repeat Medication

Other Instructions:
_____
_____

Call 911 for SEVERE symptoms not responding to treatment if unable to reach parent/guardian or physician.

Symptoms: ☐ Wheezing ☐ Coughing
☐ Shortness of breath or chest tightness
☐ Other_____

Student instructed on proper use and administration of medication? ____ Yes ___No

Student able to use medication without assistance? ____ Yes ___No
If No what assistance is needed _____
_____

Health Care Provider Signature:_____Date_____

Health Care Provider Telephone: Fax: _____

Asthma - Children with asthma have swollen, sensitive airways that lead to episodes of breathing difficulty. There is no known cure for asthma, but it can be controlled effectively.

Triggers - Asthma triggers are things which can asthma worse immediately or slowly over time.		
☐ Exercise	☐ Pollen	☐ Animals
☐ Mold	☐ Chalk dust or dust	☐ Tobacco Smoke
☐ Food	☐ Strong Odors or Spray, Smoke	☐ Cold or Respiratory Illness
☐ Carpet	☐ Change in Temperature	☐ Dust Mites
☐ Cock Roaches	☐ Other	

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Update: (11/5/2012)DJG

Student Contract for Self-Carried Medication
Asthma Action Plan

Student: _____ Grade: _____ School: _____

Parent: _____ Telephone Number: _____

Licensed Health Care Provider: _____ Telephone Number: _____

Medication: _____ Dose and Time: _____

Medication is permitted in accord with district policy. Both student's health care provider and parent/guardian must complete Asthma Action Plan. Student's name must appear on inhaler/container.

Student Responsibilities

I plan to keep my inhaler with me at school rather than in the office.
I agree to use my inhaler in a responsible manner, in accordance with my licensed health care provider's orders.
I will notify the school health office or main office if I am having more difficulty than usual with my health condition i.e. asthma.
I will not allow any other person to use my inhaler.

Student's Signature: _____ Date: _____

Parental Authorization
I hereby give my permission for my child (named above) to self-administer medication during school hours. A licensed physician has prescribed this medication. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent (Guardian) Signature: _____ Date: _____

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- ❑ Emergency Action Plan complete and on file at school.
- ❑ Student demonstrates correct use and administration
- ❑ Recognizes proper and prescribed timing for medication.
- ❑ Agrees to carry medication or keep in established location.
- ❑ Knows health condition well.
- ❑ Will not share medication or equipment with others.

School Nurse Signature: _____ Date: _____

Principal's Signature: _____ Date: _____