

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 ...		
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Call 911 for SEVERE symptoms not responding to treatment if unable to reach parent/guardian or physician. </div>	_____ CALL Parent _____ Repeat Medication	Other Instructions: _____ _____
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Symptoms: <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Shortness of breath or chest tightness <input type="checkbox"/> Other _____ </div>		
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.		
<input type="checkbox"/> Exercise	<input type="checkbox"/> Pollen	<input type="checkbox"/> Animals
<input type="checkbox"/> Mold	<input type="checkbox"/> Chalk dust or dust	<input type="checkbox"/> Tobacco Smoke
<input type="checkbox"/> Food	<input type="checkbox"/> Strong Odors or Spray, Smoke	<input type="checkbox"/> Cold or Respiratory Illness
<input type="checkbox"/> Carpet	<input type="checkbox"/> Change in Temperature	<input type="checkbox"/> Dust Mites
<input type="checkbox"/> Cock Roaches	<input type="checkbox"/> Other	

Parent Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

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: _____

- 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: _____