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:

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.

Fax: 440.888.1377