

# 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:

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**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.**