ISD 318 Asthma Action Plan

School Year: _____

This **student** is being treated for **Asthma**, the information below should assist you if the student has asthma symptoms during school hours.

Student's Name: _____ ***Date of Birth***: _____

Parent/Guardian: _____ Phone: _____ *The*

above student/patient is taking the following medication for ***Asthma***

Quick – Acting "Relief" medications as needed for: Cough, wheezes, and shortness of breath

Check	Medication/Dose	Directions
	Albuterol HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	Albuterol 0.5 cc in 2 cc NS per nebulization	Every 4 hours prn
	Albuterol pre-mixed vial per nebulization	Every 4 hours prn
	Xopenex pre-mixed vial per nebulization ☐ .63 mg ☐ 1.25 mg	Every 4 hours prn
	Xopenex HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	Other:	

Pre-exercise Medications ☐ Only as needed

Check	Medication/Dose	Directions
	Albuterol HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	Albuterol 0.5 cc in 2 cc NS per nebulization	Every 4 hours prn
	Albuterol pre-mixed vial per nebulization	Every 4 hours prn
	Xopenex pre-mixed vial per nebulization ☐ .63 mg ☐ 1.25 mg	Every 4 hours prn
	Xopenex HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	Other:	

ISD 318 recommends all students carry their inhalers at all times unless otherwise directed by parent or MD due to age constraints.

Check Box for Special Instructions:

☐ This student is capable and knowledgeable to carry this medication at all times. ☐ I recommend this student **does not** carry this medication with him/her.

☐ Peak flows are **not** recommended **or** ☐ Peak flow are: _____

☐ Approved for full participation in sports activities and physical education.

☐ Uses a holding chamber or spacer with inhaler

_____ _____

Health Care Provider/Parent Date

Parent to complete the following information:

What are your child's asthma triggers (causes) of their symptoms?

Your child's inhaler will be located: _____during school hours.
If your child:

- does not respond the medication the MD has ordered **911 will be called**
- does not have his/her inhaler with them at all times during the school day as recommended and experiences asthma symptoms **911 may be called**

Please note:

- Prescription Medication(s) will only be given with written parent permission and written orders from your Health Care Provider.
- Please notify the nurse if there are any changes made in the medication to be given (dosage change, discontinued, hold, etc.) A new order will be needed to make changes especially if a new medication is prescribed.
- **Your signature on this form also serves as a release for the nurse to exchange information with the Health Care Provider (via fax, telephone, or written) and appropriate school staff regarding medication and health issues/concerns. This information is private data and will be kept confidential.**
- I release the school personnel from any liability in relation to this request when the medication is given as ordered. I understand the school is rendering a service and does not assume any responsibility for this matter. I understand that a school nurse or designated person will administer the medication.
- Please notify the nurse of all the medication your child is taking even if they are taking it at home. This is important in case of an emergency.

Please check one of the below:

☐ My child CAN carry their own inhaler

☐ My child CANNOT carry their own inhaler

Parent Signature:_____ Date:_____ ☐

Completed parent portion of the Asthma Plan/ parent understands above statements and agrees. Nurse signature: _____ Date/Time phone review: _____

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