

**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
	<i>Albuterol HFA Inhaler 2 puffs per oral inhalation</i>	Every 4 hours prn
	<i>Albuterol 0.5 cc in 2 cc NS per nebulization</i>	Every 4 hours prn
	<i>Albuterol pre-mixed vial per nebulization</i>	Every 4 hours prn
	<i>Xopenex pre-mixed vial per nebulization</i> <input type="checkbox"/> .63 mg <input type="checkbox"/> 1.25 mg	Every 4 hours prn
	Xopenex HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	<b>Other:</b>	

**Pre-exercise Medications**

**Only as needed**

Check	Medication/Dose	Directions
	<i>Albuterol HFA Inhaler 2 puffs per oral inhalation</i>	Every 4 hours prn
	<i>Albuterol 0.5 cc in 2 cc NS per nebulization</i>	Every 4 hours prn
	<i>Albuterol pre-mixed vial per nebulization</i>	Every 4 hours prn
	<i>Xopenex pre-mixed vial per nebulization</i> <input type="checkbox"/> .63 mg <input type="checkbox"/> 1.25 mg	Every 4 hours prn
	Xopenex HFA Inhaler 2 puffs per oral inhalation	Every 4 hours prn
	<b>Other:</b>	

**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?

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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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