This form is valid for school year ______

School Asthma Action Plan

PARENT SECTION

Last Name: ______________________ First Name: ______________________

Date of Birth (mm/dd/yyyy): ______________________ School: ______________________ Grade: ______

Parent/Guardian Name: ______________________ Parent/Guardian Phone #: ______________________

I, the undersigned, as legal parent/guardian of the above named student request a designated member of the school staff make available the following listed medication(s) to my child as prescribed on this School Asthma Action Plan and in accordance with California law.

Parent/Guardian Signature: ______________________ Date: ______________________

MEDICAL TREATMENT PLAN *(To be completed by Healthcare Provider)*

Asthma symptoms are triggered by: ☐ Exercise ☐ Dust Animal dander ☐ Strong Odors or Fumes ☐ Mold

GO: Student is doing well!	Daily Controller Medicines			
Student has all of these:	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN	WHERE
* Breathing is good * No cough or wheeze				☐ Home ☐ School
* Sleep through the night * Can go to school and play				☐ Home ☐ School
				☐ Home ☐ School

Exercise Pretreatment Instructions *(check all that apply)*

☐ Give 2 puffs of quick relief inhaler 15 minutes prior to recess/physical education as needed.

☐ May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or ______________________.

CAUTION – Slow Down!	Quick Relief Medicine at School			
Student has any of these:	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN	WHERE
* Cough * Mild wheeze				
* Trouble breathing				

DANGER – Get Help!	IF ANY OF THE FOLLOWING ARE HAPPENING SEEK EMERGENCY CARE:
CALL 911	* Student doesn't feel any better 20-30 minutes after taking quick relief medicines. * Breathing is hard and fast * Nose opens wide * Can't talk well * Lips and fingernails are blue * Unrelieved coughing * Wheezing maybe gone (asthma is so bad that air is not moving) * Very weak and tired

Additional Comments: ____

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☐ I have instructed this student in the proper use of his/her medications. It's my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

☐ In my professional opinion, this student should not carry his/her medication and it should be stored in the health office.

______________________ MD/DO/NP/PA ______________________

Printed Name of Provider — Phone

______________________ ______________________ ______________________

Provider Signature — CA License Number — Date