*This page is required **ONLY** if your child has a current diagnosis of Asthma OR your provider may provide his/her own Action Plan*

2020 - 2021

ASTHMA ACTION PLAN: Residential & Non-Residential Students

- ***This section MUST be completed by the Asthma Care Provider (not the parent/guardian)***
- ***Provider: You may substitute your own Action Plan in place of this page***

Student's Name: _____

Daily Controller Medication/Inhalers:

1.
2.
3.
4.

Rescue (quick-relief) Medication/Inhaler:

1.
2.

Nebulizer: _____ YES _____ NO

1.

Action Plan: *please add or mark through Action Plan items as needed*

1. Continue Daily Controller Medications (if prescribed).
2. Use rescue inhaler or nebulizer every _____ hours as needed for asthma symptoms.
   - Stay with student.
   - Recheck symptoms after 10 minutes.
3. If no improvement, contact parent/guardian for further instructions.
4. Call 911 immediately if:
   - Unable to reach parent/guardian.
   - Child is struggling to breathe & there is no improvement after using rescue inhaler.
   - Lips & fingernails are blue or gray.
   - Trouble walking & talking due to shortness of breath.
   - Loss of consciousness.
5. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or child is in the Emergency Department.

Please list other information or instructions here:

1.
2.
3.

Self-Administration: (please check one)

_____ Student can carry & use his/her inhaler at school without supervision.

_____ Student needs supervision or assistance to use his/her inhaler medication at school.

Physician/Provider:

Address: _____Date: _____

Phone #: _____ Fax #: _____ Email: _____

Provider Signature: _____ Provider Printed Name _____

I, the parent/guardian, give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with the prescribed medication and delivery/monitoring devices:

Parent Signature: _____ Parent Printed Name _____

CC: Tina Brinkman, RN/Nikki Al Khatib, RN