Holy Family Catholic School

SCHOOL ASTHMA ACTION PLAN

This document is to be completed at the beginning of each school year and kept on file with the school nurse or office of the principal.

Student's Name:_____ Grade:_____ DOB:_____

Teacher's Name:_____ School Year:_____

Parent/Guardian Name:_____ Best Phone:_____

_____

Emergency Contact Name Relationship Best Phone

A. Quick-relief Medication

Medication Name:_____

Dosage (mg/ml):_____Route:_____

Time:_____

If no relief, can be repeated _____ times _____ minutes apart.
Call 911 if minimal or no improvement.

B. Other Medication

Medication Name:_____

Dosage (mg/ml):_____Route:_____

Time:_____

If no relief, can be repeated _____ times _____ minutes apart.
Call 911 if minimal or no improvement.

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS (to be filled out by physician; select one)

☐ I have instructed _____(student's name) on proper way to use his/her inhaler. It is my professional opinion that this student should be allowed to carry and self-administer his/her asthma medication while on school property and at school-related events.

☐ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medication while on school property and at school-related events.

_____

Physician's Name Physician's Signature Phone Date

_____

Parent's Name Parent's Signature Phone Date

By signing this document, I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with the physician's instructions above.