ASTHMA ACTION /MEDICATION PLAN

CENTENNIAL SCHOOL DISTRICT

Student's Name_____ Section/Grade_____

School _____School Year _____

Parent/Guardian Name:_____ Parent/Guardian Phone #_____

Emergency Contact:_____ Emergency Phone#_____

Doctor's Name_____ Doctor's Phone#_____

Effective management of a child with asthma during school requires a partnership between the parent, doctor and the school team. In order to meet the specific needs of your child with asthma, please have your Doctor or Health Care provider complete this asthma form.

Type of Asthma _____

Asthma aggravated by: Allergies _____ Exercise _____Weather _____ Other _____

Medication(s): _____
Dosage: _____
Time(s) to be taken: _____
Frequency of additional doses (list): _____
Side Effects or Cautions (list): _____
Allergies_____
Other Medications taken_____

Peak flow reading, (personal best):_____

Instructions RE: How do you want the school to treat an acute episode? (Please be specific)

_____
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Restrictions in sports participation & school activities: (list)

Permission to carry inhaler medication on person: Yes_____ No_____

Physician's Name _____Telephone Number _____

Physician's signature _____Date Last Visit:_____

Parent/Guardian's signature_____Date_____

THIS FORM MUST BE UPDATED EVERY SCHOOL YEAR EVEN IF THERE ARE NO CHANGES.

The reverse side of this form must be completed for self-administration of asthma medication/inhalers only.

PPLH 38 2/05

AGREEMENT OF STUDENT REGARDING SELF- ADMINISTRATION OF ASTHMA INHALER MEDICATION

- ✔ I have demonstrated the correct use of the inhaler to the school health personnel. (Initial by school health personnel)_____.
- ✔ I agree to NEVER share the inhaler with another person.
- ✔ I agree to report each occasion of use of the inhaler to the school health personnel.
- ✔ I agree to come directly to the Nurse's Office if I continue to have difficulty with breathing, wheezing, or is experiencing chest tightness after using the inhaler.
- ✔ I understand if I do not follow the provisions of this policy, I may lose the privilege of carrying the asthma medication.

Student's Signature_____Date_____

AGREEMENT OF PARENT/ GUARDIAN REGARDING SELF-ADMINISTRATION OF ASTHMA INHALER MEDICATION

- ✔ My child will be responsible for carrying this asthma inhaler and will self-administer.
- ✔ My child agrees to follow the district's procedures concerning the handling and administration of this medication.
- ✔ I understand it would benefit my child for the School Nurse to be supplied with back up medication in the event the medication is lost or misplaced.
- ✔ I acknowledge that the Centennial School District bears no responsibility for ensuring that the medication is taken.
- ✔ I agree to release the Centennial School District and its school personnel from all claims of liability if my child suffers any adverse reactions from self –administration of asthma medication.

Parent/ Guardian's
Signature_____Date_____