FOR OFFICE USE: School Year: _____ Notified/Copy Given To: Classroom Teacher: _____ Teacher Initials: _____

Dickinson Public Schools

Asthma Action Plan & Authorization for Reliever Medication(09/23)

Child's name:	DOB: Teacher/Grade:
Parent/Guardian(s):	Guardian phone numbers:
Emergency contact:	Emergency Phone:
Physician/Phone:	Preferred Hospital:

Asthma Management Information

1. **Identify what Triggers an Asthma Episode (check all that apply)**
   - ☐ Exercise
   - ☐ Strong odors or fumes
   - ☐ Tobacco smoke
   - ☐ Change in temperature
   - ☐ Other: _____
   - ☐ Animals: _____
   - ☐ Foods: _____
   - ☐ Molds/Pollens
   - ☐ Respiratory infections
2. **Child's symptoms:**

   _____

   _____
3. **Reliever Inhaler/Nebulizer to Treat Symptoms:**

   Medication Name _____ Dose & Frequency _____
4. **When was this child diagnosed with asthma:** _____
5. **When was the child's last clinic or hospital visit for asthma:** _____
6. **Daily asthma or allergy medications taken at home:**

Name	Dosage/Times usually given

Asthma Action Plan

If your child appears to have asthma symptoms, school staff will do the following:

1. Retrieve inhaler/nebulizer from this location: _____
2. Administer medication as directed (see #3 on first page)
3. Allow the child to return to class/regular activity if symptoms are relieved and child's condition improves.

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4. **School personnel will seek emergency medical care if the child has any of the following:**
    - No improvement 15-20 minutes after initial treatment with medication, unable to reach parent or emergency contact.
    - Difficulty breathing: hunched over, struggling to breathe, gasping, chest & neck retracted
    - Lips or fingernails are gray or blue
    - Parent comments/instructions: _____

Provider Section (To Be Completed by Health Care Provider)

Child's Name:	DOB:

Medication Administration Options (check #1 or #2):

1. ☐ The *school* needs to administer or help this child administer this reliever medication; **or**

2. ☐ This *child* has received instruction in *self-administration,* and is able to safely use and store this reliever medication

Physician or Health Care Provider (**Print**): _____

Physician or Health Care Provider Signature (**Required**): _____

Date: _____ Phone: _____

If your facility has an Asthma Action Plan please attach a copy for child's school or complete the Asthma Action Plan on the next page

Parent Care Authorization

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to school personnel to contact my child's physician as needed; and that education/health information may be shared with staff who need to know.

Parent/Guardian Signature of Approval (Required): _____

Medication Authorization

- I give consent to Dickinson Public School personnel to store and help administer my child's reliever inhaler.

Parent/Guardian Signature of Approval (Required): _____

Self-Administration Authorization

(Please sign only if your child will keep inhaler with them & self-administer this medication)

- I request permission for and authorize my child to self-administer this reliever inhaler during school hours and district sponsored activities. I also acknowledge and understand the following: School personnel will not be legally or financially responsible for the administration of this medication and may not monitor my child's failure to self-administer it. My child and I shall be solely responsible to ensure the medication is taken as prescribed. In exchange for granting my request to permit my child to self-administer this medication, I agree: (1) To indemnify, defend and hold harmless the Dickinson Public School District, its officer employees and all other individuals working in their official capacities on behalf of the district from any claim or liability for injuries or damages resulting from the self-administration of the above-named medication; and (2) To acknowledge that I will not seek any recovery from the District for any claim or liability for injury or damages, including without limitation reasonable.

Parent/Guardian Signature of Approval (Required): _____

**Please note your child's inhaler must come in a box with a prescription label or have a prescription label attached to the inhaler. This authorization form is valid for one school year. New authorization forms must be completed prior to the start of each new school year or if there are any changes in medical status.*

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FOR OFFICE USE: School Year: _____ Notified/Copy Given To: Classroom Teacher: _____ Teacher Initials: _____

Medication Administration Documentation

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Signature

Date	Comments

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ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO — Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow:
from _____
to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

For asthma with exercise, take:

CAUTION — Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR ASTHMA CARE PROVIDER.

DANGER — Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow:
reading below _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.