ASTHMA ACTION PLAN

ALL SAINTS EPISCOPAL SCHOOL

Student Name ___________________________________ Sex M F Date of Birth __________________

Teacher ________________ Grade _____

Health Care Provider who treats child's asthma ____ Phone ________________________ Fax ______________________

Mother's Name ____ Cell __________________________________ Other Phone ___________________________

Father's Name ____ Cell _________________________________ Other Phone ___________________________

BELOW: To be completed by healthcare provider: It is my professional opinion that this student:

☐ **Should be allowed to carry and self administer the medication(s)** while on school property or at school –related events. The student has received instruction in the proper use of the medication, significant side effects to report, when to use the medication and that the medication is not to be shared with other.

☐ **Should NOT be allowed to carry and self administer the medication(s**) while on school property or at school-related events.

Albuterol or Xopenex Metered Dose Inhaler (whichever medication provided by parent/guardian)

☐ 2 puffs every 4-6 hours as needed for cough, wheezing, chest tightness, or difficulty breathing

☐ Usually has symptoms with exercise; Administer ~ 15 minutes prior to exercise

☐ Other ____

Significant Side Effects Include: Increase Heart Rate and Shakiness ☐ Other ____

Student should be allowed to return to class if: Student has improvement in symptoms and has a pulse ox of $\geq$ 92%

☐ Other ____

Length of time this treatment is authorized: Current School Year ☐ Other ____

If he/she has an Emergency during school hours, follow these steps:

Administer 2 puffs of Albuterol or Xopenex. This may be repeated twice if needed. Wait 20 minutes between treatments.

Notify parent/guardian and have parent /guardian contact our clinic for instructions.

Other ____

If student needs to use rescue inhaler more than twice per week, please have parent/guardian contact our office to review controller medications and plan of care. Thank you for working with us to keep this student from missing school.

Parent: I request that my child be assisted in taking the medication described above at school by authorized persons or permitted to medicate herself/himself as also authorized by my healthcare provider (See below). I give my permission for the nurse or administrator to share information with my child's teachers(s) and healthcare provider as needed to coordinate care.

Parent Signature ____ Date ________________________

Health Care Provider Signature ____ Date ______________________

All Saints Episcopal School
Asthma Medication
Parent Request for Medication Administration at School

Student Name _________________________ **Grade** _____ **Age** _______

Teacher ______________________ Physician's Name __________________

List any medication allergies ____

List all medication(s) student is currently taking: ______________________________________

I hereby request and authorize my child to receive the medication listed below for the treatment of asthma symptoms(persistent coughing, wheezing, chest tightness, shortness of breath, etc):

Medication:

___ Albuterol 90mcg

___ Xopenex 45 mcg

Dose:

___ 2 puffs every 4 hours as needed

___ Other

I give my permission for my Healthcare Provider and the Nurse or Headmaster of All Saints Episcopal School to share health care information if additional information is needed. My signature below indicates that I request that ASES staff administer the medication as specified above, to my child. This medication authorization is for the current school year or until rescinded by parent.

Parent/Guardian Signature _____________________ Date _________