STUDENT ASTHMA ACTION CARD

DAILY ASTHMA MANAGEMENT PLAN *Side 2, Continued:* TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

Student Name: ______________________________ **Birthdate** ____________________

- **Identify the things which start an asthma episode (if known) Check all that apply. These should be excluded from the student's environment as much as possible.**

☐ Exercise	☐ Chalkdust/ Dust	☐ Food ____________
☐ Strong Odors or Fumes	☐ Carpets in Room	☐ Molds
☐ Respiratory Infections	☐ Animals ____________	☐ Latex
☐ Change in Temperature	☐ Pollens Spring/Summer/Fall	☐ Other:

- **List all asthma medications taken each day (including at home).**

	Name	*Amount*	*When to Use*
1.			
2.			
3.			

- **Comments and Special Instructions**

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AUTHORIZATIONS:

PARENT/GUARDIAN:

☐ I want this plan to be implemented for my child at school

☐ I authorize my child to carry and self-administer asthma medications and I agree to release ASD and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medication. ☐ Yes ☐ No

☐ It is recommended that backup medication be stored with the school/school Nurse in case a student forgets or loses inhaler or inhaler is empty. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your healthcare provider regarding the asthma condition and the prescribed medication regimen.

Parent/Guardian Signature ______________________________ ***Date*** ____________________

STUDENT AGREEMENT:

☐ I understand the signs and symptoms of asthma and when I need to use my asthma medication.

☐ I agree to carry my medications with me at all times.

☐ I will not share them or use my asthma medications for any other use than what it is meant for.

Student Signature______________________________ ***Date*** ____________________

☐ Approved by School Nurse/School Principal. Back up medication is stored at school _____Yes _____ No

School Nurse/School Principal Signature ______________________________ ***Date*** ____________________

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