MADISON COUNTY SCHOOLS

v.2

Asthma Action Plan

School Year: ______

School:		Grade:	Teacher:
Student's Name:		Date of Birth:	Gender: ☐ Male ☐ Female

Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Healthcare Provider Name(s):	Phone:	

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

Life-Threatening Allergy ☐ Yes* ☐ No * Allergy to: ______

GO

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work & play

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Medication recommended prior to physical activity:		

CAUTION

You have all of these:

- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

DANGER

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking

Take these medicines and call your doctor now:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

______ (PRINTED NAME OF PHYSICIAN)

______ (SIGNATURE OF PHYSICIAN / DATE)

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

______ Parent/Guardian Signature

______ Date:

v2

School Year

AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER PRESCRIPTION ASTHMA AND/OR ANAPHYLAXIS MEDICATION

☞ *Action Plans are required by law for students diagnosed with Asthma and/or Anaphylaxis Conditions* ☜

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

Diagnosis: ______________________

Medication / Purpose: ______________________

Prescribed Dose: ______________________

TIME: (The times at which or circumstances under which medication may be administered): ______________________

HEALTH CARE PROVIDER STATEMENT

The student has asthma and/or anaphylaxis and is capable of self-administering the prescription asthma and or anaphylaxis medication. I recommend the student be allowed to carry prescription medication as prescribed.

☛ **Provider's Signature/DATE** ☛ **Printed Provider Name**

Telephone: ______________________ Fax: ______________________

******** PARENT/GUARDIAN SECTION********

PARENT/GUARDIAN AUTHORIZATION

I authorize my child/student to carry and self-administer prescription asthma and/or anaphylaxis medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

☛ **Parent/Guardian Signature/DATE** ☛ **Printed Name**

Emergency contact phone number: ______________________