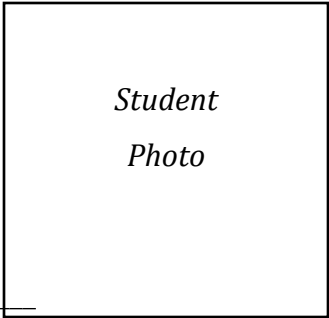




# ASTHMA ACTION PLAN



Student  
Photo

**Student Information:**

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
School: \_\_\_\_\_ Grade/Rm. \_\_\_\_\_

**Emergency Information:**

Parent(s) or Guardian(s) \_\_\_\_\_

**Mother:** Tel (W) \_\_\_\_\_ Tel (H) \_\_\_\_\_

**Father:** Tel (W) \_\_\_\_\_ Tel (H) \_\_\_\_\_

**Healthcare Provider** \_\_\_\_\_ Tel \_\_\_\_\_

In case of emergency, contact:

1. Name \_\_\_\_\_ Tel \_\_\_\_\_

2. Name \_\_\_\_\_ Tel \_\_\_\_\_

**Asthma Emergency Action:**

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: \_\_\_\_\_

| Name of Medication | Dosage | Time |
|--------------------|--------|------|
|                    |        |      |
|                    |        |      |

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

**Steps for an Acute Asthma Episode (to be completed by physician)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Prescriber** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER**

Ohio Department of Health  
**Authorization for Student Possession and Use  
of an Asthma Inhaler**

In accordance with ORC 3313.716/3313.14

**A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.**

|                 |
|-----------------|
| Student name    |
| Student address |

**This section must be completed and signed by the student's parent or guardian.**

*As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

|                                   |  |
|-----------------------------------|--|
| <b>Parent /Guardian signature</b> | Date   |
| Parent/Guardian name              | Parent/Guardian emergency telephone number<br>(        ) |

**This section must be completed and signed by the student's physician.**

|                                       |  |
|---------------------------------------|--|
| Name and dosage of medication         |  |
| Date medication administration begins | Date medication administration ends (if known) |

|  |
|--|
| Procedures for school employees if the medication does not produce the expected relief |
| _____  |

**Possible severe adverse reactions:**

|  |
|--|
| To the student for which it is prescribed (that should be reported to the physician) |
| To a student for which it is <b>not</b> prescribed who receives a dose               |

|                      |
|----------------------|
| Special instructions |
| _____                |

|                            |  |
|----------------------------|--|
| <b>Physician signature</b> | Date   |
| Physician name             | Physician emergency telephone number<br>(        ) |

Adapted from the Ohio Association of School Nurses