

Runnels School Asthma Action Plan

Student _____ DOB _____ Grade _____

Contact Numbers: (mom) Home _____ Work _____ Cell _____

(dad) Home _____ Work _____ Cell _____

Emergency Contact Name _____ Phone _____

To Be Completed By Health Care Provider

Please circle student's known triggers: **pollens** **stress/anxiety** **cold air** **exercise**

Allergy (please specify) _____ other _____

Current Meds for Asthma Control

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Asthma Meds to be given at school

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Is student capable and responsible for self-administration of this medication? Yes No

May student carry inhaler (10 yrs. and older)? Yes No

Personal Peak Flow _____

If Asthma attack occurs at school follow these steps:

1. _____
2. _____
3. _____

Other special instructions: _____

Health Care Provider signature: _____ Date _____

To Be Completed By Parent/Guardian

I understand that:

- ❖ if symptoms are not relieved by steps taken above, school personnel will activate the 911 emergency system
- ❖ if my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the clinic, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.

Additional Comments:

Parent/Guardian Signature _____ Date _____