PORTLAND CHRISTIAN SCHOOL

# Asthma Action Plan

Student Name:_____ Date of Birth:_____

Grade:_____ School Year:_____

## THIS SECTION TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Diagnosis: ASTHMA

____Controlled ____Chronic ____Acute with illness ____Seasonal ____Exercise Induced

Medication/Inhaler:_____ Dosage:_____

Medication to be administered:_____

Special conditions for additional administration:_____

_____This student has been instructed by physician regarding the care, storage, and use of this prescribed medication and has the ability to determine appropriate administration of the medication.
*__*By checking this option, this student should be allowed to carry and self-administer this medication*__

_____Inhaler should be stored in School Office or Health Room and requires supervision during administration.

_____ _____
Printed Name of Physician or Healthcare Provider Date

_____ _____
Signature of Physician or Healthcare Provider Office Phone #

## PARENT/GUARDIAN AUTHORIZATION

If physician deems the student able to carry and self-administer this medication, I hereby release PCS and its employees from liability from any injuries resulting from this student carrying, maintaining and self-medicating. I agree to hold harmless PCS and its employees from any claim resulting from student's self-administration of medication to treat asthma per state law KRS158.834. If my student will be carrying his/her inhaler, I agree that it is the responsibility of the parent/guardian to require the student to be in possession of the above prescribed medication during the school day, extracurricular activities and during field trips. Replacement of expired medication is the responsibility of the parent/guardian.
I hereby acknowledge that if this medication is not self-administered or requires supervision, it may be given by trained, unlicensed PCS staff. I hereby release PCS and its employees from any liability that may occur from the administration of this medication according to physician's instructions.

Parent/Guardian gives consent to PCS employees to discuss the medical condition referenced above with Healthcare Provider to assist in planning for the student's care while at school or school events.

_____ _____ _____
Name of Parent/Guardian (Print) Signature of Parent/Guardian Date

Emergency Contact:_____ Phone#_____ Relationship_____

## EMERGENCY PLAN OF ACTION FOR STUDENTS WITH ASTHMA

1. Call EMS if wheezing or coughing has not improved after medication administration, student is having difficulty breathing, student has trouble walking or talking, student's fingernails, lips, or gum line are blue/ashen
2. NOTIFY school personnel trained in CPR/AED to care for student and initiate CPR/AED if needed prior to EMS arrival. Notify parent/guardian or emergency contact. If student is transported via EMS, a school staff member must accompany student.

PORTLAND CHRISTIAN SCHOOL

# Asthma Action Plan

## Parent/Guardian Information

Student Name:_____ Date of Birth:_____

Grade:_____ School Year:_____

List routine, daily meds taken to control ASTHMA/Allergies:_____

Physician Name & Phone #:_____

**Asthma Triggers, Symptoms and Interventions**

**Triggers** (Check all that apply):

☐ Exercise ☐ Respiratory Infections ☐ Change in Temperature ☐ Pollen

☐ Trees/Grass ☐ Molds ☐ Dust ☐ Chalk ☐ Odors ☐ Perfumes

☐Latex ☐ Animals ☐ Food ☐ Other:_____

**Signs and Symptoms** student will likely exhibit (Check all that apply):

☐Coughing ☐Wheezing ☐Labored/Difficulty Breathing

☐Other_____

Helpful Interventions or measures to be taken:_____

_____

I understand that is my responsibility as the parent/guardian to update the school throughout the year with any new medical information. Permission for administration of medication shall be effective for the current school year and all forms shall be renewed at the beginning of each school year.

_____ _____ _____

Name of Parent/Guardian (Print) Signature of Parent/Guardian Date

TO BE COMPLETED BY SCHOOL PERSONNEL

Form Received by:_____ Date Form Received:_____

School Year:_____

Student will carry inhaler on self [ ] Yes [ ] No

Student will have inhaler in Health Room [ ] Yes [ ] No