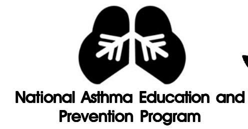
Asthma and Allergy Foundation of America

# Student Asthma Action Card



Name: ______________________ Grade: __________ Age: ______

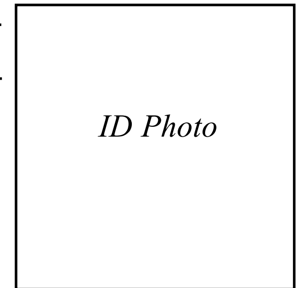
Homeroom Teacher: ______________________ Room: __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________




Emergency Phone Contact #1 ______________________________________________

Name Relationship Phone

Emergency Phone Contact #2 ______________________________________________

Name Relationship Phone

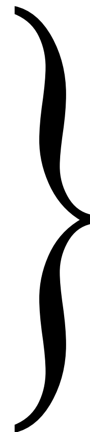
Physician Treating Student for Asthma: ______________________ Ph: __________

Other Physician: ______________________ Ph: __________

## Emergency Plan

Emergency action is necessary when the student has symptoms such as, ______________ , ______________, ______________ , ______________ or has a peak flow reading of ______________.

- **Steps to take during an asthma episode**:
  1. Check peak flow.
  2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
  3. Contact parent/guardian if ______________________________________________
  4. Re-check peak flow.
  5. Seek emergency medical care if the student has any of the following:
     - ✔ Coughs constantly
     - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
     - ✔ Peak flow of ______________
     - ✔ Hard time breathing with:
       - Chest and neck pulled in with breathing
       - Stooped body posture
       - Struggling or gasping
     - ✔ Trouble walking or talking
     - ✔ Stops playing and can't start activity again
     - ✔ Lips or fingernails are grey or blue



**If This Happens, Get Emergency Help Now!**

- **Emergency Asthma Medications**

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

*See reverse for more instructions*

## Daily Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food ______________________

☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds

☐ Other ______________________
______________________

Comments ______________________

- **Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) ______________________

______________________

______________________

______________________

- **Peak Flow Monitoring**

Personal Best Peak Flow number: ______________________

Monitoring Times: ____________ ____________ ____________ ____________

- **Daily Medication Plan**

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

## Comments / Special Instructions

______________________

______________________

______________________

## For Inhaled Medications

☐ I have instructed ______________________ in the proper way to use his/her medications. It is my professional opinion that ______________________ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ____________ should not carry his/her inhaled medication by him/herself.

______________________ Physician Signature ____________ Date

______________________ Parent/Guardian Signature ____________ Date

# LAKEVIEW LOCAL SCHOOL DISTRICT
## Parental Request for Administration of Medication

To the Parent:

The following information is necessary for any student to receive physician-prescribed medication on school premises. The FRONT and BACK of this form must be completed for each medication.

________________________________________ ____________________ ________
Name of Student | Birthdate | Age

____________________________________ _______________ __________________
School | Grade | Homeroom Teacher

1. I am requesting permission for my child named above to receive physician prescribed medication at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissable followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

____________________________________ ______________________________
Signature of Parent/Guardian | Relationship to Student

_________________________ _______________________ ________________
Home Telephone | Work Telephone | Date

# PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule, to the extent possible, the administration of medication to a student outside of school hours. When that is not possible, medications will be permitted, insofar as feasible, during school hours. Please complete every space.

______________________________________________ is under my care. I have prescribed
Name of Student

________________________________________________________________________________
Name of medication, dosage, route of administration

________________________________________________________________________________
Time(s) to be given

Beginning date:__________________________ Expiration date:_________________________

Specific instructions for
administration:________________________________________________________________

Possible side effects to watch for:___________________________________________________

Side effects to report to physician:___________________________________________________

Specific instructions including storage/sterility:________________________________________

Allergies:_______________________________________________________________________

Physician Signature:_______________________________________

Printed/Typed Physican Name:_______________________________

Physician Telephone:_____________________

Date:__________________

# LAKEVIEW LOCAL SCHOOL DISTRICT
## Authorization for ASTHMA Medication

To the Parent:

The following information is necessary for any student to receive prescribed medication for asthma on school premises.

**Please complete this section if your child is to COME TO THE CLINIC TO USE A RESCUE INHALER:**

____________________________________________ __________________ ___________

Name of Student Birthdate Age

_______________________________________ _____________ ______________________

School Grade Homeroom Teacher

1. I am requesting permission for my child named above to receive physician prescribed medication at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissable followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

____________________________________________ ________________________________

Signature of Parent/Guardian Relationship to Student

__________________________ __________________________ __________________

Home Telephone Work Telephone Date

**Please complete this section if your child is going to CARRY / USE A RESCUE INHALER at school:**

____________________________________________ __________________ ___________

Name of Student Birthdate Age

_______________________________________ _____________ ______________________

School Grade Homeroom Teacher

1. I am requesting permission for my child named above to possess / use physician prescribed medication at school.
2. I will assume responsibility for maintaining adequate for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will assume responsibility of my child reporting the need of the emergency medication to the nearest adult in supervision prior to its use, using the medication appropriately and according to the physician's prescription in the presence of the adult in supervision, and reporting its use to the Board authorized employee after its use.
4. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissable followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
5. I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

____________________________________________ ________________________________

Signature of Parent/Guardian Relationship to Student

__________________________ __________________________ __________________

Home Telephone Work Telephone Date