Asthma Action Plan 2024-2025 School Year

Child's Last Name:_____ **Child's First Name:**_____

Date of Birth:_____ **Room Number:** _____

Asthma Risk: ☐ Mild ☐ Moderate ☐ Severe

Triggers (list):_____

Control Medications Taken at Home:_____

EMERGENCY ACTION PLAN

1. Contact school nurse at _____
2. Encourage student to remain calm, take slow, deep breaths, and sit upright.
3. Administer emergency medications below.
4. Stay with student and monitor. Nurse will utilize pulse oximeter as needed.
5. CALL 911 if symptoms persist after 15 minutes or if in doubt.
6. Notify parent or emergency contact.

CALL 911 Immediately if:

- Trouble breathing/talking due to shortness of breath
- Lips or fingernails are blue
- Medicine is not helping after 15 minutes
- No medication is available and unable to reach parent

Physician's Orders – Emergency Medication

Name of Medication	Strength and Dose to be Given	When to Administer at School

Additional Instructions: _____

_____

Medication received by: _____ Date:_____ Exp. Date:_____

Physician's Signature: _____ **Date:** _____

Physician's Name (print): _____ **Phone:** _____

Parent/Guardian's Authorization: I permit the medicine listed to be administered in school by the nurse or other trained staff. I consent to communication between the school nurse and prescribing health care provider or clinic to discuss asthma management and administration of this medication. I agree that High Hopes Development Center shall incur no liability and be held harmless against any claims of injury related to administering such medication.

Parent/Guardian's Signature: _____ **Date:** _____

Parent/Guardian's Name (print): _____ **Phone:** _____

Emergency Contact:_____ **Phone:** _____