E.H. Mellon Administrative Center

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ASTHMA ACTION PLAN/PERMIT FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Student Name:	Date of Birth:	Today's Date:
Health Care Provider:	Preferred Hospital:	School/Grade:

Asthma Severity Intermittent or Persistent: Mild Moderate Severe **Asthma Control** Well-controlled Needs better control	**Asthma Triggers Identified (things that make asthma worse):** Colds Dust Pollen Stress/emotions Exercise Strong odors Mold/moisture Gastric reflux Season: Fall Winter Spring Summer Other:

Does your child take asthma medication(s)? (Check all that apply)
On a regular basis At school on a regular basis
At home only as needed At school only as needed

Does your child have a Rescue/Emergency inhaler? Yes No Name of Medication:

Will your child carry a Rescue/Emergency inhaler at school? Yes No Sometimes – **If Yes/Sometimes please complete consent at the bottom of this form. If inhaler is to be administered by Authorized School Personnel please complete separate Medication Administration Consent (requires Physician signature).**

Should your child use the inhaler before PE? Yes No Sometimes

Where will inhaler be found while at school? Backpack/Locker Desk/classroom
Office/Medication Drawer Carries with Them

What are the symptoms your child shows during an asthma attack/ flare up?
Steps you would like the school staff to follow if you child has an asthma attack/ flare up: 1. 2. 3.

I, , give permission for my child to self–medicate the asthma medication as directed by the physician. The medication will be in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued. Also, I will obtain documentation from the physician if the medication dosage is changed. I understand that the District and my child's school have no liability for my child's self-medication. I agree to indemnify and hold harmless the District and/ or the school, along with its agents and employees, against any claim (except a claim based upon willful and wanton conduct).

I hereby authorize District Health Staff to contact the medical provider named here regarding this medication and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication/condition to District Health Staff regarding any medical concerns about this medication/condition.

I also give permission for the School Administration/School Nurse to contact the prescribing health professional about the administration of this medicine. I certify that I have administered at least one dose of the medicine to my child without adverse effects.

Date: Parent/Guardian Signature:

Printed Name: Phone Number: