ASTHMA ACTION PLAN

To be completed and signed by Physician

WAVERLY COMMUNITY SCHOOLS
Pride. Tradition. Excellence.

Effective Date: _____ to _____		
Student Name:	Date of Birth:	School Building:
Parent(s)/Guardian(s):		Phone: Alternate:
Emergency Contact:		Phone: Alternate:
Physician Name:		Phone: Fax:
Physician Signature:		Physician Emergency Phone:
Is the student able to self-medicate: ○Yes ○ No		

Go (Green)	Use these medications every day		
You have <u>all</u> of these:	Medication	How much to take	When to take
- Breathing is good - No coughing or wheezing - Sleeping through the night - Can work and play			
	For asthma with exercise, take:		
Peak Flow above: _____			

Caution (Yellow)	Continue with green zone medications and <u>add</u>:		
You have <u>any</u> of these:	Medication	How much to take	When to take
- First sign of a cold - Exposure to known trigger - Cough - Mild wheeze - Tight chest - Coughing at night			
Peak flow from ____ to ____			

Danger (Red)	Take these medications <u>and</u> call your doctor		
Your asthma is getting worse ***<u>fast</u>***	Medication	How much to take	When to take
- Medicine is not helping within 15-20 minutes - Breathing is hard and fast - Nose opens wide - Ribs show - Lips and fingernails are blue - Trouble walking and talking			
Peak flow from ____ to ____			

Check all items that trigger your asthma and things that could make your asthma worse:

- ○ Chalk Dust
- ○ Cigarette smoke and second hand smoke
- ○ Colds/Flu
- ○ Dust mites, dust, stuffed animals, carpet
- ○ Exercise
- ○ Mold
- ○ Ozone Alert days
- ○ Pests – rodents and cockroaches
- ○ Pets – animal dander
- ○ Plants, flowers, cut grass, pollen
- ○ Strong odors, perfumes, cleaning products, scented products
- ○ Sudden temperature changes
- ○ Wood smoke
- ○ Foods: _____ _____
- ○ Other: _____ _____

Special Instructions:

updated 12/2015es

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Active for School Year: _____

STUDENT MEDICATION REQUEST FORM

This form must be *completed in full and returned with a physician's signature* to current school office before administration of medication can take place within the school. *OTC medications also require a physician's signature.*

Student Name & DOB:	**School & Grade:**
Parent/Guardian:	**Phone:**
Parent/Guardian:	**Phone:**
Name of Prescription or OTC Medication:	
Form of Medication (circle one): Tablet/Capsule Liquid Inhaler Medi-pen Other: _____	
Time to be administered:	
Is this medication for episodic or emergency events only? (circle one): Yes No	
Is the student able to self-carry this medication? (circle one): Yes No	
Possible side effects from medication:	
Health Care Provider Signature: **Printed Name:**	**Phone:**
Preferred Hospital:	**Fax:**
Emergency Contact:	**Phone:**

I give permission for school personnel to share this information, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I understand and agree that when school personnel administer medication to my child as indicated above, I will not hold the personnel and school district liable in any criminal action or for civil damages. Reference: Act #157, Public Acts of 1971, effective 11/24/1971, Section 378.

All medications must be collected by a parent or guardian within one week of the last day of classes for students. Any medications left after that time will be properly disposed of.

_____

Parent Signature **Date**

School Office Use Only	Administration Office Use Only
Date Received:	**Date Received from Building:**
Location of Medication:	**Date Recorded:**
Reminder: **Scan/Email to School Nurse & Administration Office**	**Reminder:** **Set Alert in PowerSchool, Upload to CEO**