Asthma and Allergy Foundation of America

Student Asthma Action Card

National Asthma Education and Prevention Program

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.			

School Asthma Action Plan

Student Name_____ Teacher/Team_____ School Year_____

1. Triggers that might start an asthma episode for this student:

☐ Exercise ☐ Animal Dander ☐ Cigarette smoke, strong odors ☐ Respiratory Infections
☐ Pollens ☐ Temperature Changes ☐ Foods_____ ☐ Emotions (e.g. when upset)
☐ Molds ☐ Irritants (e.g. chalk dust) ☐ Other_____

2. Control of the School Environment:

_____ Environmental measures to control triggers at school _____
_____ Pre-Medications (prior to exercise, choir, band, etc.) _____
_____ Dietary Restrictions _____

3. Peak Flow Monitoring:

How often does your child check peak flows? _____ Never Sometimes Always
Personal Best Peak Flow_____ Monitoring Times_____

4. Routine Asthma, Allergy, and Anaphylaxis Medication Schedule

Medication Name	Dose/Frequency	When to Administer	
		At Home	At School

5. Field Trips: Asthma Medications and supplies must accompany student on all field trips. Staff member must be instructed on correct use of the asthma medications and bring a copy of the Asthma Action Plan and Contact Phone Numbers.

1. Parent to Contact _____
   Phone Number(s) _____
2. Other Person to Contact in Emergency _____
   Phone Number(s) _____

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Legal Guardian Signature _____ Date _____

Reviewed by the School Nurse _____ Date _____

MARYVILLE R-II SCHOOL DISTRICT
AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION AT SCHOOL OR AFTER-SCHOOL ACTIVITIES

In accordance with School Board policy JHCD, a student may carry and self-administer medication for the treatment of Asthma, Anaphylaxis, or Diabetes on district property, at district-sponsored activities, and in transit to and from school or activities in accordance with law. The district will not allow any student to self-administer medications unless:

1. The medication is prescribed by the student's physician and is in original container with directions for use.
2. The physician has provided a written treatment plan for the condition for which the medication is prescribed and certifies that the student is capable and responsible in use of the medication. The student must demonstrate to the physician or physician's designee the skill necessary to use the medication.
3. The student has demonstrated proper self-administration technique to school nurse.
4. The student's parent/guardian has signed a statement authorizing self-administration of the medication.

Name/Dose of Medication _____

Diagnosis for which medication is needed _____

I authorize the Maryville School District to allow my child to carry and self-administer medication for Asthma, Anaphylaxis, or Diabetes. I acknowledge that the district and its employees or agents will incur no liability as a result of any injury arising from the self-administration of such medication. The school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior that could pose a safety or health risk.

Student's Name _____ Grade _____

Parent/Guardian Signature _____ Date _____

The above student has been instructed in correct administration of above medication and has demonstrated correct technique. In my opinion, this student shows capability to carry and self-administer the above medication.

Physician Signature _____ Date _____

MARYVILLE R-II SCHOOL DISTRICT
PARENTAL PERMISSION FOR
STUDENT MEDICATION ADMINISTRATION

The Maryville R-II School District's Medication Policy requires written parental/guardian consent prior to giving any prescription or over-the-counter medications at school. This form is to be completed for each medication given. **Medication is to be supplied in the original container with only a 30 day supply each time brought by a parent/guardian or other responsible adult. A new written medical provider order must be presented for any medication changes.**

If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one to be kept at school and one for home. **THE VERY FIRST DOSE OF MEDICATION WILL NOT BE GIVEN AT SCHOOL.**

Student Name_____ Grade_____

Name/Dosage of Medication_____

Time to be Taken _____

Form of Medication/Treatment ____Tablet/Capsule ____Liquid ____Inhaler ____Other

Reason for Medication_____

Physician's Name_____

Medication to be Given From_____ TO_____
(Start Date) (End Date)

When was First Dose of Medication Given? _____

List Student's allergies_____

I request the above medication or treatment be administered to my child at school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school nurse immediately if any information provided on this form changes. I give permission for the school nurse to communicate with the above physician or medical provider regarding any questions or concerns about the above medication or treatment. I also agree to pick up any remaining medication within one day after the last day of school or the school will dispose of the medication.

_____ _____
Parent/Guardian Signature Date