Donegal School District
Asthma Action Plan

Parents, you have indicated that your child currently has asthma. So that we can better care for your child, please complete the following information and return this form to the school nurse immediately.

Student Information

Name of Student:____D.O.B.__________________

Grade:___________ Homeroom Teacher or Class:____

In case of an emergency, contact in order:

1. Name:_________________________________ Phone:__________________ Relationship_________________________________
2. Name:_________________________________ Phone:__________________ Relationship_________________________________
3. Name:_________________________________ Phone:__________________ Relationship_________________________________

Doing well:	Take these medicines every day for control and maintenance
No coughing ,wheezing, chest	
tightness, or difficulty breathing	
Can work, play, exercise, perform	
usual activities without symptoms	

Caution/Getting worse:	Continue your green zone medicines PLUS take these quick relief medicines
Coughing, wheezing, chest	
tightness, or difficulty breathing	
Symptoms with daily activities,	
work, play, and exercise	
Awakening at night with symptoms	

Alert!!	FOR EXTREME TROUBLE BREATHING/SHORTNESS OF BREATH: GET IMMEDIATE HELP!
Difficulty breathing, coughing ,	
wheezing not helped with	
medications	
Trouble walking or talking due to	
asthma symptoms	
Not responding to quick relief	
medications	

*Please list all other Asthma Medications:____

**Inhaler Use: this student was taught and demonstrates the capability for self-administration and for responsible behavior in the use of the medication. He/she has permission to carry and self-administer his/her inhaler, as prescribed, when needed. *The student shall notify the nurse or designee immediately following each use.* If the student abuses or ignores the school policies, the inhaler may be confiscated and the privilege to carry the medication may be revoked.

________________ ________________

Yes **No**

____ ________________ ______________________________

Physician's Signature **Date** **Phone number**

*Signing verifies that the above plan has been prescribed by you, the child's physician, and should be carried out by the school he/she attends.

____ ____________________________

Signature of Parent/ Guardian **Date**

**Signing verifies that you, the parent/guardian, give permission for the school staff t carry out the administration of the above prescribed plan in your absence and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its administration.