SPRINGPORT PUBLIC SCHOOLS
ASTHMA / ALLERGY ACTION PLAN

PARENT STATEMENT

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED ASTHMA MEDICATION OR EPI-PEN IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student Name _____ DOB _____ Gender (M) (F)
Address _____
School: (ES) (MS) (HS) Teacher/Grade _____

ASTHMA MEDICATION

Name _____ Dose _____ Frequency _____

Behavioral Intervention - KEEP CALM

1) Keep student calm
2) Provide quiet space
3) Provide emotional support
4) Have student breathe slowly
5) Do not leave child alone
6) Have "best buddy" or sibling present for support

EPI-PEN (Allergy and Instructions)

Allergy: _____ Instructions: _____
_____

Parent/Guardian Signature _____ Date: _____

PHYSICIAN'S STATEMENT

ASTHMA MEDICATION(S) AND/OR EPI-PEN

Name(s) _____ Dose _____ Frequency _____

Comments/Special Instructions: _____
Beginning Date_____ Ending Date _____

Identify the things that may trigger asthma flare-ups. (Check each that applies to the student.)

( ) Exercise
( ) Chalk dust or dust
( ) Food _____
( ) Change in temperature
( ) Carpets in the room
( ) Animals _____
( ) Strong odors or fumes
( ) Pollens
( ) Molds _____
( ) Other _____

Does this child have exercise-induced asthma? YES _____ NO _____
Does this child use an inhaler before engaging in physical exercise and if wheezing during physical activity?
YES _____ NO _____

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education, etc.) _____
_____

Please check all that apply:

( ) I have instructed this child in the proper way to use his/her **inhaled medications**. It is my professional opinion that this child **should be allowed to carry and use** that medication by him/herself.
( ) I have instructed this child in the proper way to use his/her **epi-pen**. It is my professional opinion that his child **should be allowed to carry and use** his/her epi-pen by him/herself.
( ) It is my professional opinion that this child **SHOULD NOT** carry his/her **inhaled medications**.
( ) It is my professional opinion that this child **SHOULD NOT** carry his/her **epi-pen** by him/herself.

Physician Signature _____ Telephone:_____

Printed/Typed Name _____ Date: _____