Washington Township School District

ASTHMA ACTION PLAN

place picture here

Name:_____D.O.B._____ GRADE/TEACHER:_____

Diagnosis: ☐ Asthma ☐ Reactive Airway Disease ☐ Exercise Induced Asthma

Medication(s) Prescribed

☐ Albuterol _____ puffs _____w/ spacer _____ w/o spacer
☐ Albuterol _____ vial via nebulizer

☐ Xopenex _____ puffs _____ w/spacer _____ w/o spacer
☐ Xopenex _____ vial via nebulizer

☐ Maxair _____puffs _____w/spacer _____ w/o spacer

☐ Specify other:_____
_____

When needed
For cough, wheeze, shortness of breath and colds:
- Give every 4 hours as needed
- Also may use 15-30 minutes prior to exercise as needed

Medication can be repeated (First notify parents if symptoms persist)
If needed, give the above medication:
- Every 30 minutes for a total of **3** treatments.
- **If student is not improving activate EMS (call 911)**

Side effects
Increased heart rate, facial flushing, jitteriness

Triggers may include

☐ Viral Infections
☐ Exercise
☐ Allergens
  ☐ dust mites
  ☐ pollen
  ☐ mold
  ☐ pets
  ☐ pests
  ☐ odors
  ☐ foods _____
  ☐ other_____
☐ Extreme Weather Changes/cold air

Peak flow

☐ Peak flow meter baseline #____
☐ Peak flow meter not applicable

PERMISSION TO SELF-ADMINISTER:

☐ This student has been trained and **is capable of self-administration** of the medications noted above in accordance with NJ Law. The student shall carry the metered-dose inhaler (MDI) medication(s) at all times in school and at all school-sponsored events and activities.

☐ This student is not approved to self-medicate.

PHYSICIAN SIGNATURE:_____Date:_____

PHYSICIAN STAMP:

EMERGENCY CONTACTS-CALL 911

DOCTOR:_____PHONE:_____
PARENT/GUARDIAN:_____PHONE:_____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:_____ PHONE:_____
NAME/RELATIONSHIP:_____ PHONE:_____

I give consent for administration of the above noted medications to be given by the school nurse. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration or self-administration (if applicable) of the above noted medications to my child. I shall indemnify and hold harmless the district, its employees, and agents against any claims arising out of the administration or self-administration (if applicable), or my child's possession (if applicable), of the above noted medication(s). If the student is able to self-administer, **I understand my child shall keep the metered dose inhaler (MDI) medication(s) prescribed for self-administration with him/her at all times** in school and at all school-sponsored events and activities. I hereby give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medication. I understand that this information will be shared with school staff/faculty. This consent is only valid for the school year in which this form was completed.

PARENT/GUARDIAN SIGNATURE:_____Date:_____

For **self-administration** only: _____ I will provide the school nurse with back up medication(s)
_____ I will **NOT** provide the school nurse with back up medication(s)

If your child can not self-administer you **MUST provide the school nurse the prescribed medication(s)**