Wilmington Area School District
Asthma Action Plan

Student Name: ______________________________ **DOB:** ______________________ **Grade:** _______ **Homeroom:** _______

Asthma Severity: • Mild Intermittent •Mild Persistent •Moderate Persistent •Severe Persistent
Asthma Triggers: •Colds •Exercise •Animals •Dust •Smoke •Food
•Weather •Other: ____

Early Warning Signs: How does your student look, sound, act before an Asthma attack? (circle all that apply)
•Wheezing •Coughing •Chest Tightness •Pain in Chest •Pain in Back •Shortness of Breath
•Difficulty Breathing •Little energy for play •Other: ____

Medications

Daily:
Name: ____ Dose: ____

Name: ____ Dose: ____

Emergency/Rescue:
Name: ____ Dose: ____

Name: ____ Dose: ____

Student's ability to use inhaler:
•Independent •Nursing staff to instruct/assist •Nursing staff to supervise
Location of Rescue inhaler:
•student will carry on their person (must have permission in writing from private physician and paperwork handed to school nurse)
•Student will have in locker/sports bag for after school activities (must have permission in writing from private physician and paperwork handed to school nurse)
•Student will keep in the health office

Physical Education

PE days and times: ____
•Needs to use inhaler before PE or any physical activity

Contact Information

Emergency Calls
1. Mother: ________________________ Home: ________________________ Work: ________________ Cell: ____________

2. Father: ________________________ Home: ________________________ Work: ________________ Cell: ____________

3. Emergency Contact: ____ Home/Cell: _______________________________

4. Physician/Clinic for Asthma Management:____
Phone: ____ Fax #: ____

Physician Signature: ____ **Date:** ________________________
(Required)
Please Review, Sign and Return this form to the School Nurse.
- The information above is correct and should be used when managing my student's asthma at school.
- The School Nurse may share this Asthma Action Plan with all school personnel interacting with my student.
- The School Nurse may contact the family asthma doctor listed above to discuss this information.
- If the student is sent to the emergency department(ED), a follow-up report can be faxed to the school nurse.

Parent/Guardian Signature: ____ **Date:** _________________________
(Required)
Parents are required to keep track of the expiration date of the inhaler and replace when nearing expiration:
Expiration date: ____

WILMINGTON AREA SCHOOL DISTRICT

400 WOOD STREET

NEW WILMINGTON, PA 16142

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name____________________________________DOB_________________

Building____________________________ Grade/Homeroom___________________ Name of

Medication (A separate form must be completed for EACH medication that is to be administered)

____

Dosage____

Desired time of administration____

Reason medication prescribed ____

Special circumstances or Side effects____

Listing of other medications prescribed for student _________________________________

Period of time for which medication is prescribed___________________________________

Prescribing Physician's Name ____

Prescribing physician's signature OR copy of signed prescription attached

____ OR

Signed Prescription attached:______

I hereby agree to hold harmless and indemnify the Wilmington Area School District and its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action in law or equity for the administration of the medication authorized above.

____________________________________ ______________________________________ __________

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Amount of Medication received ____

By____ ____________________

Signature of Certified School Nurse Date

NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL PRESCRIPTION/MANUFACTURER'S BOTTLE OR IT WILL NOT BE ADMINISTERED AT SCHOOL.

WILMINGTON AREA SCHOOL DISTRICT
300 Wood Street New Wilmington, Pennsylvania 16142
(724) 656-8866
MS/HS School Nurse – Ext. 1030
Elementary School Nurse – Ext. 3030

ASTHMA INHALERS SELF-ADMINISTRATION BY STUDENT

Student's Name_____________________________ Grade/Homeroom _________

Name of Medication_________________________ Date Prescribed________________

Diagnosis/Reason______________________________ Length of Need ____________

Dosage____________________________________ Frequency______________

Side Effects/Special Circumstances ____

To self-medicate, the student must be able to: (check all that apply)

- ☐ 1. Respond to and visually recognize his/her name.
- ☐ 2. Identify his/her medication.
- ☐ 3. Demonstrate the proper technique for self-administering his/her medication.
- ☐ 4. Sign his/her medication sheet to acknowledge having taken the medication.
- ☐ 5. Demonstrate a cooperative attitude in all aspects of self-administration.

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria above.

____ _______________________
Physician's Signature Date

____ _______________________
Certified School Nurse's Signature Date

As parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above name medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated. The student shall notify the school nurse following each use of an asthma inhaler.

____ _______________________
Parent/Guardian's Signature Date

____ _______________________
Student's Signature Date

THIS FORM MUST BE ATTACHED TO AN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM AND AN ASTHMA ACTION/CARE PLAN.