NIAGARA FALLS CITY SCHOOL DISTRICT
ASTHMA ACTION PLAN
SECTION II - (To Be Completed By Health Care Provider)

Name:_____ Date of Birth:_____ Grade:_____

Please note: ALL ORDERS FOR PRN RESCUE INHALER MUST INCLUDE NAME OF MEDICATION, DOSE, FREQUENCY

Asthma Severity: ◯ Intermittent ◯ Mild Persistent ◯ Moderate Persistent ◯ Severe Persistent

Asthma Triggers: ◯ Colds ◯ Exercise ◯ Animals ◯ Dust ◯ Smoke ◯ Food ◯ Weather ◯ Other _____

Medications used Daily for Control and Maintenance
Breathing is good
No Cough or Wheeze
Can work/play

DAILY MEDICATION	Dosage	When and How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications used for Quick Relief of symptoms:
Coughing , Wheezing, Chest Tightness, or Difficulty Breathing.
Other_____

RESCUE MEDICATION	Dosage	When and How Often
_____	_____	_____

If no improvement may repeat after 15 minutes, Yes ◯ No ◯

PRE MEDICATION BEFORE PHYSICAL ACTIVITY

15 minutes before sports or gym, use this medicine to prevent symptoms _____ 2 puffs

◯ **YES** ◯ **NO**

Call HCP if this medicine is used more than two times a week during the day.

Call 911 and parent if symptoms are worsening or inhaler not helping after second dose , can't walk or talk well, nostrils open wide, chest or neck pulled in or lips blue.

Give Rescue Medicine again while waiting for ambulance

SELF-MEDICATION RELEASE FOR INTERSCHOLASTIC SPORTS: Middle School and High School only

This patient has been instructed in the proper use of his/her asthma medication. It is requested that he/she be permitted to carry the medication as I consider him/her responsible and self- directed. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Yes_____ No_____

Health Care Provider Signature_____ Date_____

Please Note: THE DECISION OF SELF-DIRECTION ULTIMATELY REMAINS WITH THE SCHOOL NURSE AS PER NYS EDUCATION DEPT. GUIDELINES.Adapted from: managing Asthma; A guide for Schools

NIAGARA FALLS CITY SCHOOL DISTRICT – HEALTH SERVICES
ASTHMA ACTION PLAN
SECTION 1

TO BE COMPLETED BY PARENT/GUARDIAN*: The New York State Education Department requires that all students who have ongoing chronic illnesses* ***provide yearly medical updates to your child's School Health Services. Please have your child's Health Care Provider complete section II on back of this form. RETURN THIS FORM WITH ALL APPROPRIATE SUPPLIES TO THE SCHOOL NURSE ON THE 1ST DAY OF STUDENT'S RETURN TO SCHOOL.***

Student Information:

Name_____ DOB_____ Grade_____

Parent(s)/Guardian(s) name: _____

IN CASE OF EMERGENCY, CONTACT:

1. Name_____ Phone_____ Relationship_____
2. Name_____ Phone_____ Relationship_____
3. Name_____Phone_____ Relationship_____

Daily Management: Identify things that may start, or trigger an asthma episode for your child. (Check all that apply)

◯ Exercise ◯ Strong Odors ◯ Respiratory Infections ◯ Chalk Dust ◯ Changes in Temperature ◯ Carpeting

◯ Animal fur/dander ◯ Pollens ◯ Molds ◯ **Insect Bites/Stings** ◯ **Foods_____**

◯ ***EPI-PEN required? Yes_____ No_____*** *Personal best Peak Flow*_____

*List environmental control measures or dietary restrictions that student needs*_____

Asthma Emergency Action: The following are possible signs of an asthma emergency, 911 and parent will be called IMMEDIATELY IF:

***** Student has difficulty breathing, walking or talking ** Student has blue or gray discoloration of lips of fingernails***
***** Student has failure of medication to reduce worsening symptoms***

I request that my child receive the medication as prescribed by our Health Care Provider. The NYS Education Dept. requires that all ***medication is to be furnished by me in a properly labeled original container from the pharmacy and must be brought to the School Health Office by a parent or guardian.*** It is the policy of the School District that these procedures must be followed or the school will not be responsible for the administration of the medication.

SELF MEDICATION RELEASE FOR INTERSCHOLASTIC SPORTS : ***Middle and High School Only:*** **My child has been instructed in the proper use of his/her Asthma medication. I request that he/she be permitted to carry the medication on his/her person. I consider him/her responsible and self- directed. YES_____ PARENT INITIAL _____ NO_____ PARENT INITIAL _____**

PARENT SIGNATURE REQUIRED: I grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider pertaining to this Asthma Action Plan. I authorize the Health Office to share this information with school personnel as needed.

Parent /Guardian signature_____ Printed Name:_____

HEALTH CARE PROVIDER TO COMPLETE SECTION II ON REVERSE SIDE **F-30 5/12**

For School Health Office Use: Gym Days_____ Teacher_____