# Asthma Action Plan Consent Form for Carrying and Self-Administering Medications in School

**Student**_____ **Grade/Homeroom**_____

**********

## Section to be Completed by Physician

**Medication**_____ **Dose/Frequency**_____

**Reason for administration**_____

**Potential serious reaction**_____

**The above student is qualified and able to carry and self-administer the stated medication:**

**Date**_____

_____

**(Signature of physician, registered nurse practitioner or physician assistant)**

**********

## Section to be completed by parent/guardian

**I agree to the above student carrying and self-administering the stated medication. I release the United School District and its employees of any responsibility for the benefits or consequences of the self-administered prescribed medication.**

**Date**_____

_____

**(Signature of Parent/Guardian)**

DEPARTMENT OF HEALTH

Edward G. Randall, Governor
Cathie B. Johnson, M.D., M.P.H., Secretary of Health

# Asthma Action Plan

(To be completed by Doctor/Nurse)

PHILADELPHIA ALLIES AGAINST ASTHMA
Giving Children Freedom to Breathe

Name | Birth Date | Effective Date

School | Parent/Guardian | Parent's Phone

Doctor/Nurse's Name | Doctor/Nurse's Office Phone

Emergency Contact After Parent | Contact Phone

**Asthma Severity:** ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

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

## TAKE THESE MEDICINES EVERYDAY

**Child feels good:**
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

Peak flow in this area:
_____ to _____

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |
| | | |

Green

**20 MINUTES BEFORE EXCERCISE USE THIS MEDICINE:**

| | | |
|---|---|---|
| | | |

## IF NOT FEELING WELL — TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

**Child has *any* of these:**
- Cough
- Wheeze
- Tight Chest

Peak flow in this area:
_____ to _____

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |

Yellow

*Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.*

## IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! — TAKE THESE MEDICINES

**Child has *any* of these:**
- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

Peak flow below:
_____

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |

Red

**IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:**
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature | Date

Health Care Provider Signature

Adapted from the NYC Childhood Asthma Initiative

Adapted forms the NHLBI

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