Grandville Public Schools

Health Room Office
4700 Canal SW
Grandville, Michigan 49418
Phone: (616) 254-6455 Fax : (616) 254-6462

Asthma Action Guide

Student Name _____ Bldg. _____
Birthdate _____ Grade _____ School Year _____

School Day Medication Orders:

(NOTE: School DOES NOT stock emergency medications. These must be provided by the parent! Medications are likely to be given by non-medical staff.)

DAILY MEDICATION- Complete this section if the student needs daily or prevention medication at school:

Medication Amount When to Use (ex: 15" prior to PE)_____

_____

RESCUE MEDICATION-Complete this section if the student needs emergency asthma medication (rescue inhaler) at school:

Medication Amount Route Frequency When to Use _____

_____

PHYSICIAN:

Is student permitted to carry and self-administer this medication? Yes No

I have reviewed this plan with the student and parent. Please follow the school plan as outlined above.

Physician Signature _____ Date _____
Type/Print Name of Physician _____ Phone _____

I give my permission for school personnel to assist with the management of my child's asthma, including administration of medication if necessary. I further give my permission for school personnel to contact my child's physician directly if there are concerns of questions regarding my child's asthma management. I will notify the school of changes in my child's condition.

Parent Signature _____ Date _____
Emergency Contact (Phone #) _____

Staff Use:
Form received by _____ Date _____
Copy to Nurse by _____ Date _____
Copies to Staff by _____ Date _____

Notes