Penn Manor School District
Asthma Action Plan

Nurse's Office Direct Fax Number: 1-888-510-8011

Name: _____DOB:_____ Grade: ____ School:_____

Yellow Zone
(Coughing, wheezing, tightness or shortness of breath)

Medication:_____

Route/Dosage: _____ Time of Administration:_____

Discontinue Date: _____ Possible Side Effects: _____

Special instructions: _____

Red Zone
(Rescue medication didn't help, trouble breathing, talking or walking, lips or fingernails blue)

Medication:_____

Route/Dosage: _____ Time of Administration:_____

Special instructions: _____

Call 911 immediately if unable to contact your health care provider and/or treatment has been ineffective.

SELF CARRY

☐ **NO** It is my professional opinion that this student **SHOULD NOT** be allowed to carry and use the inhaler independently.

☐ **YES** This student has received instruction in the proper use of the inhaler. It is my professional opinion that this student **SHOULD** be allowed to carry and use the inhaler independently.

School Nurse
The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine. Student has received instruction from the student's licensed physician, CRNP, or PA, on proper safety precautions for the handling and disposal of the asthma inhaler including acknowledgement that the student will not allow other students to have access to the prescribed medication and that he/she understands appropriate safeguards.

CSN Name _____ CSN Signature _____ Date_____
Student Name _____ Student Signature_____ Date _____

SIGNATURES
Healthcare Provider

Name _____ Signature _____ Date_____ Phone (___) _____-_____

Parent/Guardian

Name _____ Signature _____ Date_____ Phone (___) _____-_____
Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the administration of the above prescribed plan in your absence, acknowledges that the school is not responsible for ensuring the medication is taken, and relieves the Board and its employees of responsibility for the benefits or consequences of such medication and its administration. I give permission to the doctor, school nurse, and other health care providers to share information about my child's asthma to help improve the health of my child.

Emergency Contact #2 _____ Relationship _____ Phone (____) _____-_____