Name_____ Date_____ School_____ Grade___

Niagara Falls City School District

Department of Athletics and Health Services

ASTHMA ACTION PLAN

In order to provide your child with the safest environment for learning, 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 of this form. **RETURN THIS FORM WITH ALL APPROPRIATE SUPPLIES TO THE SCHOOL NURSE ON THE 1ST DAY OF STUDENT'S RETURN TO SCHOOL.**

PARENT SIGNATURE REQUIRED: I hereby 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 the information indicated in this Asthma Action Plan. **I authorize the Health Office to share this information with school personnel as needed.**

_____ _____

Signature: Parent/Guardian Printed Name: Parent/Guardian

SECTION I : TO BE COMPLETED BY PARENT OR GUARDIAN

Student Information

Name of Student_____ D.O.B._____

Physical Education Days and Times:_____

Emergency Information

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

Mother: Work Phone_____ **Father:** Work Phone_____

Home Phone_____ Home Phone_____

Cell Phone_____ Cell Phone_____

In case of emergency, contact:

1. _____

2. _____

Daily Management: identify things that may start, or trigger an asthma episode. (circle all that apply)

Exercise	Strong odors or fumes	Respiratory Infections
Chalk dust	Changes in Temperature	Carpeting
Animal fur/dander	Pollens	Molds
*Insect bites/Stings	*Food _____	*Epi-pen required? Yes____ No____

Personal best Peak Flow_____

List any environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode._____

Asthma Emergency Action

The following are possible signs of an asthma emergency, SEEK EMERGENCY MEDICAL HELP IMMEDIATELY IF:

- Student has difficulty breathing, walking or talking
- Student has blue or gray discoloration of the lips or 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 School and High School only:
My child has been instructed in the proper use of his/her Asthma medication and 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_____ DATE_____

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Name_____ Date_____ School_____ Grade___

HEALTH CARE PROVIDER TO COMPLETE SECTION II ON REVERSE SIDE

SECTION II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER:
Diagnosis: (circle one)
Severe asthma Moderate Asthma Mild Asthma Exercise induced Asthma

Other: _____

Medications to be given at School –***Please Note: Students requiring rescue inhalers or rescue nebulizer must have a completed Health Care Provider order below and a valid inhaler/nebulizer in school..***

Name of Medication	Dosage	Route	Time	Possible side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

All Other Current Medications:

Name of medication	Dosage	Route	Time	Possible side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

STEPS FOR AN ACUTE ASTHMA EPISODE
(to be completed by health care provider)
1.
_____

2.
_____

3.
_____

May participate in physical education program without restriction? _____Yes _____No
If no, list restrictions
_____

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 and it is requested that he/she be permitted to carry the medication on his/her person or to keep same in his/her locker or physical education locker, as we 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_____ Initial ____ No_____Initial_____

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.** ***National Heart, Lung and Blood Institute, national Institutes of health, U. S. Dept. of health and Human Services, and the fund for the Improvement and Reform of Schools and teaching, office of educational Research and Improvement ,U.S.. department of Education.***

F-30 4/04