Butler Area School District
Asthma Action Plan

School Year _____/_____

Must be completed each school year

Student Name: _____ Birth Date:_____ Grade:_____ Room:_____

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

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather

Other:_____

Please circle all asthma related answers to show child's condition over the last year.

- School days missed: none_____ 1-3 _____ more than 5_____
- Emergency room visits: none_____ 1-3 _____ more than 5_____
- Hospital admissions: none_____ 1-3 _____ more than 3 _____
- Student has medication (inhaler/nebulizer) at school? Yes_____ No_____

Early warning signs (check all the apply)

____wheeze	____cough	____chest tightness
____pain in chest	____pain in back	____short of breath
____difficulty breathing	____little energy to play	____other (_____)

Medications

Take at home	Dose	Route	Frequency
Take at school	Dose	Route	Frequency

Side Effects: _____

20 minutes before exercise, this medication should be used.

Medication	Dose	Route	Frequency

****Please notify school nurse when your student required medication before school due to asthma symptoms.****

I, the Parent/Guardian, do hereby release, discharge, and hold harmless the Butler Area School District, it agents and employees, from any and all liability, and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

I give my permission for the school nurse to use the information provided to share with Butler Area School District personnel and for the nurse to contact my child's asthma physician listed below to discuss my child's conditions as needed.

I give permission for the fax transmittal of this form between School Nurse and Physician Office.

Parent/Guardian signature:_____ Date:_____

Home Phone: _____ Work Phone: _____

Both Parental and Physician Authorizations must be received before medication can be administered.

Physician's signature:_____ Date:_____

Printed Name:_____ Phone Number:_____