MONTOURSVILLE AREA SCHOOL DISTRICT
INDIVIDUAL STUDENT
ASTHMA ACTION PLAN

Dear Parent/Guardian,

You have told us that your child has asthma. Our goal is to prevent or help to manage asthma episodes in the school setting. Please complete the asthma plan below and return it to your child's school nurse. The information will be shared with the appropriate school personnel such as your child's teacher(s). This information will help us work with your child to minimize unnecessary restrictions, feelings of being treated differently, and possible absenteeism. As always, please inform your child's school nurse of any changes in his/her medical condition or medication.

Thank you,

School Nurse

School year ____- _____

Student's Name _____ Grade: _____

Physician treating child's asthma: Dr. _____ Phone: _____

Emergency Contacts:

Mother: _____
Home # _____
Work # _____
Cell # _____

Father: _____
Home # _____
Work # _____
Cell # _____

Identify the triggers which start an asthma episode (check all that apply)

[] exercise
[] respiratory infections
[] change in temperature
[] animals
[] food _____
[] strong odors or fumes
[] chalk dust/dust
[] carpets in rooms
[] pollens
[] molds
[] other
_____
_____

Peak Flow Monitoring: Personal Best Peak Flow #._____

Monitoring times: _____ _____ _____ _____ _____

Daily Medication (related to asthma)

Name	Dosage	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Inhaled Medications:

[] I have instructed _____in the proper way to use his/her _____ (name of inhaler). It is my professional opinion that he/she is able to: 1. Recognize visually his/her name 2. Identify his/her medication 3. Demonstrate a cooperative attitude in all aspects of self-administration of medication. 4. Demonstrate appropriate technique for administration 5. Go to the nurse's office for evaluation following administering the medication.

[] It is my professional opinion that _____ should NOT carry his/her inhaled medication on him/herself.

_____ _____
Physician Signature Date

I agree to adhere to the protocol listed above. I understand the above medication is the sole responsibility of the student. Failure to demonstrate safe self-administration, including but not limited to, abuse, misuse, or non-compliance, will result in loss of privileges to carry and self administer medication.

_____ _____
Parent/Guardian Signature Date Student Signature Date

Must be completed each school year.