ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Asthma Emergency Action Plan)

Student Information:

Student: _____ Date of Birth: ___ / ___ / ___

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and Times: _____

Emergency Information:

Parent(s') or Guardian(s') names: _____

Mother: (work) _____ (home) _____

Father: (work) _____ (home) _____

Physician's Name: _____ Telephone: _____

In case of emergency, contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Asthma Emergency Action

The following are possible signs of an asthma emergency:

1. Difficulty breathing, walking or talking
2. Blue or gray discoloration of the lips or fingernails
3. Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

1. Activate the emergency medical system in your area. Phone: _____
2. Call parent/guardian or physician.

Triggers: _____

_____ Personal best peak flow: _____

FILE: JHCD-AF6

All current medications:		
Name of Medication	**Dosage**	**Time**

Medications to be Given at School (if any):		
Name of Medication	**Dosage**	**Time**

Steps for an Acute Asthma Episode (to be completed by physician)**:**
1.
2.
3.
4.

Parent's/Guardian's Signature: _____

Physician's Signature: _____

Reviewed by School Nurse: _____
(Name) (Date)

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Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented: 02/18/2004

Clinton School District #124, Clinton, Missouri