COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

ASTHMA ACTION PLAN

Name: _____ Date of Birth: _____ School: _____

TO BE COMPLETED BY PARENT:

I request that designated District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures. I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it.

_____

Parent/Guardian First and Last Name Signature of Parent/Guardian Date

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:

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

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Smoke ☐Dust ☐Weather ☐Pollen ☐Air Pollution ☐Other:_____

Name of Medication:_____ Dosage Prescribed:_____

Time/Frequency**(no ranges)**:_____ Route:_____

Indication:_____ ☐Spacer ☐ No Spacer

Name of Medication:_____ Dosage Prescribed:_____

Time/Frequency**(no ranges)**:_____ Route:_____

Indication:_____ ☐Spacer ☐ No Spacer

PRECAUTIONS, POSSIBLE ADVERSE EFFECTS, STORAGE: _____

_____

☐In my professional opinion, the student's well being is in jeopardy unless the **medication is carried on his/her person while at school**. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

☐This student requires assistance, **keep medication in the health office**

Treatment Plan:

1. Sit the child down and reassure the child.
2. Assist child with the inhaler as directed above.
3. Wait _____ minutes. If there is no improvement, repeat steps 2 and 3.
4. If there is still no improvement follow plan identified by symptom below:

Symptoms	Inhaler	Nebulizer	911
Tightness in chest, wheezing, coughing			
Difficulty breathing or speaking			
Blue color around mouth, chest pain, cannot walk because it is too hard to breath, lips or fingernails gray or blue, feeling drowsy			
List other:			

_____

Physician First and Last Name Signature of Physician Telephone

_____

Address Date

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE ALL MEDICATION NEEDS TO BE PICKED UP ON THE LAST DAY OF SCHOOL OR IT WILL BE DISCARDED

Rev. 5/18, 6/19, 3/23, 5/23, 6/24

DISTRITO ESCOLAR UNIFICADO DE COVINA-VALLEY - SERVICIOS ESTUDIANTILES

PLAN DE ACCIÓN PARA EL ASMA/ASTHMA ACTION PLAN

Nombre: _____ Fecha de nacimiento: _____ Escuela: _____

PADRES/TUTOR LEGAL DEBEN COMPLETAR:

Autorización y Cláusula de los Padres/Tutores: Solicitó que a mi estudiante se le ayude con el medicamento recetado en la escuela. Asumo toda la responsabilidad de proveer todo el medicamento y debo entregarlo, o que sea entregado a la escuela por otro adulto responsable, y acepto las pólizas y procedimientos del Distrito. Doy mi permiso para el intercambio de información médica tocante la administración del medicamento en la escuela con el médico licenciado y el farmacéutico.

_____

Nombre y apellido de Padres/Tutores Firma de Padres/Tutores Fecha

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:

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

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Smoke ☐Dust ☐Weather ☐Pollen ☐Air Pollution ☐Other:_____

Name of Medication:_____ Dosage Prescribed:_____

Time/Frequency**(no ranges)**:_____ Route:_____

Indication:_____ ☐Spacer ☐ No Spacer

Name of Medication:_____ Dosage Prescribed:_____

Time/Frequency**(no ranges)**:_____ Route:_____

Indication:_____ ☐Spacer ☐ No Spacer

PRECAUTIONS, POSSIBLE ADVERSE EFFECTS, STORAGE: _____

_____

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List other:			

_____

Physician First and Last Name Signature of Physician Telephone

_____

Address Date

ESTA SOLICITUD EXPIRA AL FINAL DEL AÑO ESCOLAR. DEBEN RECOGER TODOS LOS MEDICAMENTOS EL ULTIMO DIA DE ESCUELA O SERÁ DESECHADA

Rev. 5/18, 6/19, 3/23, 5/23, 6/24