MINERSVILLE AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

ASTHMA ACTION PLAN

NAME: _____ GRADE/SECTION: _____DOB: _____

Asthma Triggers: ____Colds/Illness ____ Exercise ____ Animals ____Weather ___Dust/Smoke

____Food _____ ___Other:_____

Name of Dr.: _____Phone #: _____

Symptoms of asthma attack (Ex. Coughing, Wheezing, Shortness of breath, Chest tightness, etc.)

_____

_____

Doctor's Orders:

School Year: _____

_____Inhaler Medication/Dosage: _____

Student is qualified to carry and self-administer inhaler _____Yes _____ No _____ (**Dr. Initials**)

_____Nebulizer Medication/Dosage: _____

_____Other _____ Dosage: _____

_____Other _____ Dosage: _____

Doctor's Signature: _____ Date: _____

Emergency Contacts: In the event of an asthma attack, the following contacts will be notified:

1. _____ _____ _____
   Name | Relationship to Student | Phone Number
2. _____ _____ _____
   Name | Relationship to Student | Phone Number
3. _____ _____ _____
   Name | Relationship to Student | Phone Number

If condition worsens/warrants emergency treatment, 911 will be contacted.

My signature below confirms that the school is not responsible for ensuring the medication is taken and relieves the MASD and its employees of responsibility for the benefits or consequences of the prescribed medication.

Parent/Guardian Signature: _____

My signature below confirms that I have received adequate instruction from the prescriber on proper safety precautions for the handling and disposal of the asthma inhaler, including acknowledgement that I will not allow other students to have access to the prescribed medication.

Student Signature: _____