Dallastown Area School District
Asthma Action Plan

Student Information

Name of Student: _____ D.O.B.: _____

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and Times:
_____

Emergency Information

Parent(s')/Guardian(s') Names:
_____

Mother Telephone (W): _____ Father Telephone (W): _____

Telephone (H): _____Telephone (H):_____

Physician's Name: _____ Telephone: _____

In case of emergency, contact:
1. _____

2. _____

Asthma Emergency Action

The following are possible signs of an asthma emergency:
- Difficulty breathing, walking, or talking.
- Blue or gray discoloration of the lips or fingernails.
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken are:
- Activate the emergency medical system in your area; Phone: _____.
- Call parent/guardian or physician.

Triggers:
_____
_____

Personal best peak flow
_____

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

_____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature