DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

ASTHMA ACTION PLAN & CONSENT FORM

LAST NAME_________________________________ FIRST NAME__________________________ DOB__________

SCHOOL_______________________________________GRADE__________SCHOOL YEAR________________

TO BE COMPLETED BY PHYSICIAN *PAGE 1 OF 2*

PLEASE PROVIDE EXACT DOSE, DOSE RANGES NOT ACCEPTED

QUICK RELIEF MEDICATION____ [ ] GENERIC OK

DOSE_____________________________ TIME___________________________ [ ] USE WITH SPACER

FOR ***AS NEEDED*** CHECK OFF SYMPTOMS BELOW, GIVE INHALER AS DIRECTED ABOVE

[ ] NOISY BREATHING [ ] COUGHING [ ] SHORTNESS OF BREATH [ ] CHEST TIGHTNESS

[ ] DIFFICULTY BREATHING [ ] OTHER____

[ ] MAY REPEAT DOSE FOR ABOVE SYMPTOMS EVERY __________________ HOURS

STRENUOUS ACTIVITY/ P.E.

[ ] USE QUICK RELIEF MEDICATION AS DIRECTED ABOVE _______________ MINUTES BEFORE P.E. OR STRENOUS ACTIVITY

OTHER INSTRUCTIONS/ INFORMATION

TARGET PEAK FLOW____________________________________ [ ] CHECK BEFORE MEDICATION

ASTHMA TRIGGERS____

OTHER MEDICATIONS AT SCHOOL____ [ ] GENERIC OK

DOSE____________________________________ROUTE___________________ TIME______________________

OTHER INSTRUCTIONS____

MEDICATIONS USED AT HOME

MEDICATION___________________________________ DOSE___________ TIME__________ROUTE_________

MEDICATION___________________________________ DOSE___________ TIME__________ROUTE_________

STAMP

PHYSICIAN SIGNATURE____

DATE____

ASTHMA ACTION PLAN & CONSENT FORM

LAST NAME____ FIRST NAME________________________________

TO BE COMPLETED BY PARENT / GUARDIAN *Page 2 of 2*

HOSPITAL____ [ ] TAKE TO NEAREST HOSPITAL

PHYSICIAN NAME____ PHONE_____________________________

SPECIALIST NAME____ PHONE_____________________________

EMERGENCY CONTACTS

1.) NAME____ RELATION________________________

HOME#_________________________ CELL#_________________________ WORK#___________________________

2.) NAME____ RELATION________________________

HOME#_________________________ CELL#_________________________WORK#___________________________

3.) NAME____ RELATION________________________

HOME#_________________________ CELL#_________________________WORK#___________________________

AUTHORIZATION & CONSENT

- I authorize school personnel to assist with the above medication for my child according to physician instruction. I understand that trained, non-medical personnel may assist with this medication (Ed Code Sec 49423 and 49480) and may contact physician for clarification purposes.
- This form must be renewed whenever the prescription changes and at the beginning of each school year.
- I understand that it is my responsibility to bring medication to Health Office in pharmacy labeled container and that medications must not be expired. I understand that it is my responsibility to provide the necessary supplies and equipment (including a copy of operating instructions.) Medications and supplies must have student’s name clearly marked.
- While the school will make every effort to cooperate, the student must assume responsibility for coming to the Health Office for medication.
- I request that my child have above prescribed medications on field trips or in case of disaster, according to physician instruction. All over the counter medications must be included in prescription.
- I understand that by signing below I agree to release from liability the district, its officers, employees and agents for any loss, damage, injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the district, its officers, employees and agents related to the assistance of medication to my child.
- I give consent for the District Nurse/School Personnel to communicate with authorized healthcare provider when necessary.

PARENT/GUARDIAN SIGNATURE____**DATE**____________