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

****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_____

SIDE EFFECTS: _____

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

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**_____