ישיבת עקיבא
FARBER
HEBREW DAY SCHOOL

Effective Date: _____

ASTHMA ACTION PLAN

Student Name: _____Grade: _____ Date of Birth: _____

MEDICATION TO BE ADMINISTERED *-Include dosing and times, if appropriate:*

Medication 1: _____ Dose: _____ Time: _____

Medication 2: _____ Dose: _____ Time: _____

Medication 3: _____ Dose: _____ Time: _____

Does this student have **exercise induced** asthma? _____Yes _____No

Should this child use an inhaler **before engaging in physical exercise** and if wheezing during physical activity?

_____Yes _____ No

Activity Restrictions (please list): _____

Asthma triggers (please list): _____

WHAT TO DO IN AN ACUTE ASTHMA EPISODE: **(Note to physician: Please be detailed. School personnel will use this information for direction in an acute situation).**

_____
_____
_____

Please check all that apply:

_____ This student is to use an inhaler before engaging in physical activity and/or if wheezing during physical activity.

_____ I have instructed this student in the proper way to use his/her inhaled medications. It is my professional opinion that this student **should** be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that this child **should not** carry his/her inhaled medications by him/herself.

_____ I have instructed this student in the proper use of a peak flow meter. His/her personal best peak flow is _____.

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

I give my permission and authorization for this medication to be administered as prescribed above and for doing so, I hereby release from liability and agree to indemnify any personnel or volunteers of Farber Hebrew Day School for any action or inactions associated with the administration of medication to the above student.
Parent/Legal Guardian Signature: _____
Phone Number: _____Home _____Work