Asthma Action Plan for Home and School

Name _____________________________________________________ Date _____________ Phone (_______) _______-____________ Signature ________________________________________________

Parents/Guardian

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____________________________________________________ Date _____________ Phone (_______) _______-____________ Signature ________________________________________________

School Nurse

The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____________________________________________________ Date _____________ Phone (_______) _______-____________ Signature ________________________________________________

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Please send a signed copy back to the provider listed above.