COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

ASTHMA ACTION PLAN

Name: _____ Date of Birth: _____ School: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:

Asthma Severity: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Smoke ☐Dust ☐Weather ☐Pollen ☐Air Pollution ☐Other:_____

MEDICATION	DOSE, TIME, FREQUENCY, INDICATION
Inhaler: ☐Spacer ☐ No Spacer	
Nebulizer:	
Other:	

☐ **BEFORE EXERCISE**: _____ to _____ minutes before exercise, take _____ medication listed above.

PRECAUTIONS, POSSIBLE ADVERSE EFFECTS, STORAGE: _____

_____

☐In my professional opinion, the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

☐This student requires assistance, keep medication in the health office

Treatment Plan:

1. Sit the child down and reassure the child.
2. Assist child with inhaler as directed above.
3. Wait _____ minutes. If there is no improvement, repeat steps 2 and 3.
4. If there is still no improvement follow plan identified by symptom below:

Symptoms	Inhaler	Nebulizer	911
Tightness in chest, wheezing, coughing			
Difficulty breathing or speaking			
Blue color around mouth, chest pain, cannot walk because it is too hard to breath, lips or fingernails gray or blue, feeling drowsy			

_____

First and Last Name of Physician Telephone Signature of Physician

_____

Address Date

Thank you, Covina-Valley Health Services Office: 626-974-6435 ; Fax: 626-974-6436

COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

ASTHMA ACTION PLAN

TO BE COMPLETED BY PARENT:

Authorization and Disclaimer from Parent/Guardian: I request that my student be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

Parent/Guardian First and Last Name	Signature of Parent/Guardian	Date

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE ALL MEDICATION NEEDS TO BE PICKED UP ON THE LAST DAY OF SCHOOL OR IT WILL BE DISCARDED

Rev. 5/18, 6/19, 3/23, 5/23

DISTRITO ESCOLAR UNIFICADO DE COVINA-VALLEY - SERVICIOS ESTUDIANTILES

PLAN DE ACCIÓN PARA EL ASMA

Nombre: _____ Fecha de nacimiento: _____ Escuela: _____

Contacto de emergencia: _____ Teléfono del contacto de emergencia: _____

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER / SER COMPLETADO POR UN MEDICO CON LICENCIA

Asthma Severity: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Smoke ☐Dust ☐Weather ☐Pollen ☐Air Pollution ☐Other:_____

MEDICATION	DOSE, TIME, FREQUENCY, INDICATION
Inhaler: ☐Spacer ☐ No Spacer	
Nebulizer:	
Other:	

☐ **BEFORE EXERCISE**: _____ to _____ minutes before exercise, take _____ medication listed above.

PRECAUTIONS, POSSIBLE ADVERSE EFFECTS, STORAGE: _____

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☐In my professional opinion, the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable
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Blue color around mouth, chest pain, cannot walk because it is too hard to breath, lips or fingernails gray or blue, feeling drowsy			

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First and Last Name of Physician Telephone Signature of Physician

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Address Date

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DISTRITO ESCOLAR UNIFICADO DE COVINA-VALLEY - SERVICIOS ESTUDIANTILES

PLAN DE ACCIÓN PARA EL ASMA

PADRES/TUTOR LEGAL DEBEN COMPLETAR:

Autorización y Cláusula de los Padres/Tutores: Solicito que a mi estudiante se le ayude con el medicamento recetado en la escuela. Asumo toda la responsabilidad de proveer todo el medicamento y debo entregarlo, o que sea entregado a la escuela por otro adulto responsable, y acepto las pólizas y procedimientos del Distrito. Doy mi permiso para el intercambio de información médica tocante la administración del medicamento en la escuela con el médico licenciado y el farmacéutico.

Nombre y apellido de Padres/Tutores	Firma de Padres/Tutores	Fecha

ESTA SOLICITUD EXPIRA AL FINAL DEL AÑO ESCOLAR. DEBEN RECOGER TODOS LOS MEDICAMENTOS EL ULTIMO DIA DE ESCUELA O SERÁ DESECHADA