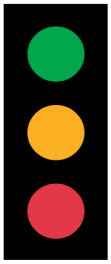
ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

GO — Use these daily controller medicines:

from _____
to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION — Continue with green zone medicine and add:

from _____
to _____

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER — Take these medicines and call your doctor now.

Peak flow:
reading below _____

- Ribs show (in children)

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

'iolani School Student Self Medication Administration Form for School Year _____

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name: _____DOB: _____

Allergies: _____

Medication: _____Dosage: _____Route: _____

Reason for medication or diagnosis: _____

Self-administration of medication by student : Students who require emergent medication for the treatment of asthma, anaphylaxis, seizures, or diabetes will be allowed to carry and self administer medications with completed consent on file in Magnus Health.

This **Student Self Medication Administration** form is required and must be signed by the student's physician/healthcare provider and parent verifying the necessity and student's ability to self administer the medication appropriately. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

Students are responsible for bringing these medications on any off campus excursions or school sponsored trips.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis): _____and have determined that he/she requires access to personal emergency medication during school hours.

2. Name of Medication:_____

3. Dosage & Route: _____

4. I believe this student is able to carry and administer his or her own medication (excluding controlled substances) at the appropriate time and in the appropriate way.

Please check: ____YES _____NO *I understand that self-administered medication is not provided by or monitored by the school staff.

Physician's Signature: _____Date: _____/ _____/ _____

Printed Name: _____Phone: _____

PARENT/GUARDIAN STATEMENT

I/We, the undersigned Parent(s) Guardian(s) of _____give consent for my/our child to self-administer the above medication. I/We hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by 'Iolani School staff. I will also reinforce with my child, that they are not to share medications with others. * Parent / Student are responsible to have the medication available at school.

X _____ ____/ ____/ ____

(Parent/Guardian Signature) Date

Home Phone: _____Work: _____Cell: _____

X _____ ____/ ____/ ____

(Parent/Guardian Signature) Date

Home Phone: _____Work: _____Cell: _____