GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

SCHOOL ASTHMA ACTION PLAN

Student's name:________________________________ Grade:________ DOB:_____________

Teacher's Name:_______________________________ School Year:________

Physician:____ Phone:___________________

PHYSICIAN TO COMPLETE INFORMATION BELOW

DAILY TREATMENT PLAN
Please list any medications taken daily to manage asthma, including nebulizer treatments.

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******************************EMERGENCY PLAN*******************************

Steps to take during an asthma episode:

Notify parent/guardian and administer emergency medications:

A. Bronchodilator (Quick-relief medication): ____

Dosage ____

Call 911 or EMS if minimal or no improvement

Can be repeated for severe breathing difficulty ____times ____minutes apart while waiting for EMS to arrive.

B. Other medications or instructions: ____

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Physician's Signature Date

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

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Parent/Guardian's Signature Date

Revised 06/2019