COUNCIL ROCK SCHOOL DISTRICT
ASTHMA ACTION PLAN/EMERGENCY ACTION PLAN

Name:_____DOB:_____DATE:_____

Asthma Severity: ___ Mild Intermittent ___ Mild Persistent ___ Moderate Persistent ___Severe Persistent

Asthma Triggers: _____

Child feels good: Every Day Medicines

MEDICINE	HOW MUCH	WHEN TO TAKE IT

EXERCISE ENDUCED FLARE UP

MEDICINE	HOW MUCH	WHEN TO TAKE IT

If Not Feeling Well: Cough, Wheeze, Tight Chest: Take Every Day Medicines and Add these Rescue Medicines. Call the doctor if needed more than 2x/week

MEDICINE	HOW MUCH	WHEN TO TAKE IT

If medicine is not working or child has any of these symptoms: Breathing hard and fast, nose opens wide, can't walk or talk well, ribs show with breathing. If symptoms do not improve, dial 911 for help

MEDICINE	HOW MUCH	WHEN TO TAKE IT

Please check below:
□ YES □ NO Both the medical provider and the parent feel that the child may carry their emergency medication
Student must verbalize/demonstrate understanding of self carry and/or self-administration of medications to school nurse.

Health Care Provider Printed Name _____PHONE:_____

Health Care Provider Signature: _____DATE:_____

Parent/Guardian Consent

I give my permission for my child to receive the following medication ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. I understand that the medications will be given as directed according to my child's licensed prescriber's directions. Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding their medical condition(s).

Parent Signature:_____DATE:_____

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MEDICATION/TREATMENT GUIDELINES

- The Medication/Treatment Dispensing Form on the reverse side must be completed by both the prescribing licensed provider (physician, dentist) and the parent/guardian for all FDA approved medication (prescription and over the counter) that must be administered during the school day. No medication will be administered without the proper completion of the Medication/Treatment dispensing form.
- Administration of all medications will be given in accordance with Council Rock School District's Medication Policy and in accordance with the Pennsylvania Department of Health guidelines for Pennsylvania schools for the administration of medications and emergency care.
- Medication will be administered to a student during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. If possible, prescribing licensed providers should time administration of medication to be given at home, before or after school.
- Prescription medication as well as non-prescription medications must be delivered to the school nurse in the original labeled pharmacy container or box by a parent/guardian.
- Failure to provide documentation will require the parent/guardian to be present in school to administer the medication personally.
- Under no circumstances will the first dose of any medication be given at school due to the risk of an adverse reaction.
- Acetaminophen or Ibuprofen for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of a parent or guardian as noted on the student's emergency information form.
- In accordance with Act 187 of the school code and CRSD procedures, students requiring rescue inhalers, Epi-pens, Diabetic medications/supplies may be permitted to self-carry and/or self-administer medications with a completed permission form. In addition to the completion of the permission form, self-administration also requires a competency assessment by the school nurse.

Student Agreement:

☐ I have been trained in the use of my emergency medication;

☐ I agree to carry my emergency medication with me at all times

☐ I will notify a responsible adult immediately if Epipen is used to call 911

☐ I will not share my medication with other students or leave it unattended

☐ I will not use my medications for any other use than what it is prescribed for

Student Signature _____Date:_____