KNOX COUNTY SCHOOLS
HEALTH SERVICES
MEDICAL STATEMENT/ ASTHMA ACTION PLAN

Student Name_____ D.O.B._____
School_____ Teacher_____ Grade_____

**********Healthcare Provider To Complete**********

Triggers which may start an asthma episode:

- ☐ Respiratory Infections
- ☐ Exercise
- ☐ Animals
- ☐ Pollen
- ☐ Dust/ Dust Mites
- ☐ Mold
- ☐ Smoke/Pollution
- ☐ Weather/Temperature
- ☐ Cold Air
- ☐ Allergies:_____
- ☐ Emotions
- ☐ Strong Odors and Sprays
- ☐ Foods:_____
- ☐ Medications:_____
- ☐ Other:_____

Control of School Environment
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode
_____

Medication Orders

Medication	Dose / Route /Frequency	When to use
1._____	_____	_____
2._____	_____	_____

Comments/Special Instructions_____

For Inhaled Medications

- ☐ I have instructed_____ in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- ☐ It is my professional opinion that_____ should not carry his/her inhaled medication by him/herself.

Emergency Plan

1. Give medication as listed above. Student should respond to treatment in 15-20 minutes.
2. Contact parent/guardian if_____
3. Seek emergency medical care if the student has any of the following:
   - ☐ Coughs constantly
   - ☐ No improvement in 15 minutes after initial treatment with medication
   - ☐ Difficulty breathing with : chest and neck pulled in with breaths, nostril flaring, stooped posture, gasping, shortness of breath.
   - ☐ Trouble walking or talking
   - ☐ Lips or fingernails are blue or purple
   - ☐ Other_____

Signature of Health Care Provider_____ Date_____
Address_____ City_____ State_____ Zip Code_____
Phone_____ Fax_____

**********Parent/ Guardian To Complete**********

I agree with the above orders as completed by my health care provider.
I, the parent /guardian of the above named student, acknowledge that the school and its employees and agents shall incur no liability as a result of any injury sustained by the student or any other person from student possession or self-administration of the inhaler

Parent / Guardian Signature _____ Date_____
Nurse Signature_____ Date_____

In the event of a medical emergency, school personnel will call 911 and notify the parent/guardian at the numbers listed below.

Father_____ Work_____ Cell_____ Home_____

Mother_____ Work_____ Cell_____ Home_____

AD-H-503 (7/15)