ASTHMA AGREEMENT AND ACTION PLAN

Holy Family Catholic School

Student's Name: _____ Student's Grade: _____ Sex: ☐ Male ☐ Female Birth Date: _____ *mm/dd/yyyy*

Parent/Guardian Name: _____

Teacher's Name: _____

In the event of a medical emergency for my student, I understand that Holy Family Catholic School will make every attempt to contact me. If the emergency is life-threatening or I cannot be contacted, I authorize the principal or his/her designee, into whose care my student has been entrusted, to consent to any emergency medical treatment that a licensed health care professional or dentist may deem necessary.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care. This authorization shall remain effective for the duration of enrollment at Holy Family Catholic School and updated annually by me unless I revoke it in writing. I also understand that all costs of transportation, hospitalization, and emergency care shall be my responsibility.

To my knowledge the information on this plan is correct and complete. To safeguard my student's health, the school may share this information with school staff to provide a safe and healthy environment for my student.

Students requiring medication at School (prescriptive) including inhalers/epinephrine will require a completed (Medication Authorization Form) on file for each school year, signed by the the parent.

AGREED AND SIGNED:

PARENT/GUARDIANS

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ **Date** _____

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ **Date** _____

PRINCIPAL

Name of Principal: **Bridgit Arkoosh**

Signature of Principal: _____ **Date** _____

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Student's Name: _____ Weight: _____ History of Anaphylaxis: ☐ Yes ☐ No If yes, need epinephrine

Describe the experiences your child experiences before or during an asthma attack: _____

What triggers your child's asthma attack?

☐ Temperature Change ☐ Dust ☐ Strong odors/fumes

☐ Pollen ☐ Food ☐ Respiratory Infection ☐ Chalk ☐ Illness/Cold

☐ Animals ☐ Mold ☐ Carpet ☐ Perfume ☐ Smoke

☐ Exercise ☐ Other _____ ☐ Seasonal (List time of year) _____

The child's asthma is: ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced ☐ Intermittent

YELLOW - CAUTION

Minor difficulty breathing

Shortness of breath

Cough or wheeze

Tightness in the chest

1. Stop activity, sit child upright, be reassuring and calm.
2. Give medicine listed

Medicine	How Much To Take	When To Take It

Shake inhaler before each puff and have child hold breath for 5 seconds or as long as comfortable

RED - ALERT

Major difficulty breathing

Very short of breath

Constant cough

Nose opened wide

RED - 911 ALERT

Lips/fingernails blue

Trouble walking/talking

1. Stop activity, sit child upright, be reassuring and calm.
2. Give medicine listed

Medicine	How Much To Take	When To Take It

Shake inhaler before each puff and have child hold breath for 5 seconds or as long as comfortable

3. Call 911 if still in the Red - Alert Zone for 15 minutes or if child is in RED - 911 Alert Zone
4. Call Parent/Guardian

List Daily Medications: _____

Comments/Special Instructions: _____

_____

Name of Parent/Guardian (Print) Signature of Parent/Guardian Telephone Date