Chapelwood School for Young Children
11140 Greenbay Houston, Texas 77024
Nurse: 713-465-4469

Asthma Action Plan

Childs Name:____ **Birthday:**___________________

Name of Childs Doctor:_____________________________________ **Phone Number:**_______________

Inhaler Brand:____ **Spacer: Yes** ☐ **No** ☐

Emergency Contact: ____**Phone Number:** ______________
(Please attach any additional forms you may have from your doctor regarding your child's condition)

Severity Classifications	Triggers	
Mild Persistent: ☐	Colds ☐	Animals ☐
Intermittent: ☐	Exercise ☐	Dust ☐
Moderate Persistent: ☐	Seasonal ☐	Pollution ☐
Severe Persistent: ☐	Food ☐	Other ☐

The policy of Chapelwood School for Young Children does authorize Chapelwood's Administrative personnel or teachers to give medication That includes prescription as well as non-prescription drugs. However, pupils must be non-contagious, on long term medications, or on preventative medication for a prolonged period (fifteen days or more) that cannot under any arrangements be administered other than during school hours may take mediation in school.

- Prescription medication or non-prescription medication will be provided by the parent.
- Medication must be taken to the nurse the day the medication is to be started.
- Medication must be in the correctly labeled prescription container or manufacturer's package labeled for that student.
- Medications, other than inhalers or Epi-pens, are not to be kept in school bags or lunch boxes. They are to be kept in designated areas. All medications will be disposed of if they are not picked up by the last day of school.

I understand that the staff cannot be responsible for any asthmatic reactions or complications resulting from this medication and I hereby waive and/or release all claims, demands, and causes of action against Chapelwood School for Young Children and/or its staff related to the administering of this medication to my child at my request. I hereby grant permission for the school nurse and trained designate to administer medication to the aforementioned student according to the physician's instructions above. I understand and agree to the policies and procedures of Chapelwood School for Young Children.

Parent/Guardian Signature: _____________________________ **Date:**_____________

Printed Name: ____