

School Asthma Action Plan

Name: _____

Date: ___ ___ / ___ ___ / ___ ___

Clinician: _____

Telephone #: _____

Self-administration of medication by this student is hereby authorized by the parent/guardian and the clinician. If this student is enrolled in a school-based clinic, the parent/guardian also gives permission for the school nurse and the school-based clinic to exchange information and otherwise collaborate in the asthma management of the child.

Parent/Guardian authorization for self-administration and release of information:

Signature

Clinician's authorization for self-administration:

Signature