DALLAS TORAH CENTER
Preschool

DTC PRESCHOOL ASTHMA ACTION PLAN

Name: _____ DOB:_____

Physician Name: _____ Physician Phone: _____

Physician Fax: _____ Father Name:_____

Father Cell: _____ Mother Name:_____

Mother Cell: _____

BELOW PORTION TO BE COMPLETED BY PHYSICIAN

Asthma Medication	Dosage/ Method	Frequency	Possible side effects	Administer 15 min before phsyical activity	Length of time medications can be kept at school
				▢ Yes ▢ No	
				▢ Yes ▢ No	
				▢ Yes ▢ No	

EMERGENCY PLAN

1. _____ (medication) can be repeated for severe breathing difficulty _____ times, _____ minutes apart.
2. Call parent/legal guardian and/or 911 or EMS if minimal or no improvement.

SELF-ADMINISTRATION OF PRESCRIPTION ASTHMA MEDICINE

☐ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medications while on school property or at school related events.

☐ It is my professional opinion that _____ (student's name) should be allowed to carry and self-administer _____ (medication) while on school property or at school-related events. I have instructed the student in the proper way to self-administer the asthma medication(s). The student is knowledgeable about the medication(s) and how to administer it.

Physician's Signature: _____ **Date**: _____

BELOW PORTION TO BE COMPLETED BY PARENT/ GUARDIAN

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/ Guardian Name (Signature)** **Date**

When applicable, I give permission for my student to self-administer the prescribed medication listed above, in accordance with the physician's order, while on school property or at a school-related event or activity. Self-administration must be done in compliance with the prescription and state law.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/ Guardian Name (Signature)** **Date**