SENATOBIA MUNICIPAL SCHOOL DISTRICT
104 McKie Street
Senatobia, MS 38668
Jay Foster
Superintendent of Education

Asthma Action Plan

School Year:_____

Child's Name:_____ **DOB**_____

PHYSICIAN'S ORDER SECTION:

Name of Medication:_____ Dosage:_____

Frequency:_____

Reason: (Circle all that apply) Persistent cough Wheezing Shortness of Breath

Tightness in Chest Other:_____

Termination date at end of current school year.

List ONLY side effects that must be reported to parent or MD:_____

Please circle the appropriate indication of asthma severity for this child:

Mild Intermittent Mild Persistent Moderate Persistent Severe Intermittent

☐ Child may carry and self-administer medication (Ex: Selection of this option enables the student to keep the inhaler with them during school hours. Not recommended for K—2nd grade)

☐ Child requires supervision during medication administration.

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

Address:_____ Phone:_____

Parents complete this section.

I agree with the above Physician Order and request this medication be given to my child as ordered above.

Parent Signature:_____ Phone #_____ Date:_____