Uniontown Area School District
205 Wilson Avenue
Uniontown, PA 15401

School Asthma Plan

School Asthma Plan (completed by parent)

Name:_____ **Grade:**_____ **Age:**_____

Teacher:_____

Parent/Guardian Name:_____ **Phone(H):**_____

Address:_____ **Phone(W):**_____

Emergency Phone Contact #1:_____ **Phone:**_____
(Name)

Emergency Phone Contact #2:_____ **Phone:**_____
(Name)

Identify the things which start an asthma episode. Check all that apply:

- ❑ **Exercise**
- ❑ **Respiratory Infection**
- ❑ **Change in temperature**
- ❑ **Animals**
- ❑ **Molds**
- ❑ **Strong odors or fumes**
- ❑ **Chalk dust**
- ❑ **Carpets in the room**
- ❑ **Pollen**
- ❑ **Food**
- ❑ **Other**_____

Comments_____

_____

Briefly describe your child's symptoms when having an asthma attack:

_____

_____

I authorize the UASD to distribute medication to my child as ordered by the Physician. I release, discharge, and hold harmless the UASD, its agents and employees from any and all liability in connection with the administration of the medication.

_____ _____
(Signature) **(Date)**

OVER

Student Name:_____

School Asthma Plan (completed by physician)

Asthma Medication

Name	Frequency	Dosage
1.		
2.		
3.		
4.		

In case of an emergency, follow the procedure outline below:

_____

_____

_____

- ☐ **I have instructed (name)_____ in the proper way to use his/her medication. It is my professional opinion that she/he should be allowed to carry and use that medication by herself/himself.**

- ☐ **It is my professional opinion that (name)_____ should NOT carry her/his inhaled medication.**

_____ _____

Physician Signature **Date**