School Asthma Action Plan Permission

Student Name

Date of Birth

School Name

Teacher/Homeroom

Parent/Guardian Contact Information

Parent/Guardian 1 Name

Phone

Parent/Guardian 2 Name

Phone

Asthma Information

Asthma Triggers

Medications (at school)

Additional Instructions

Permission

I give permission for my child to carry and self-administer asthma medication as prescribed by their healthcare provider.

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Parent/Guardian Signature

Date

Healthcare Provider Signature

Date