Parent and Physician Authorized School Asthma Management Plan

Grady ISD 2020-2021 Phone: 432-459-2445 Fax: 432-459-2729

Student: ____ **Date of Birth:** ____________________
Allergies: ____ **Grade:** _________________

To be completed by parent or guardian:

I hereby give permission for my asthmatic child, _______________________, to self-administer his/her prescribed inhaler. I also state that my child is capable of self-administering the prescription asthma medication as the physician ordered and storing it safely.

Parent/Guardian Signature:____ Date: ____________________

To be completed by physician or health practitioner:

Emergency ACTION is necessary when this student has symptoms such as:

1. _________________ 2. _________________ 3. ____________________ 4. ____________________

STEPS to take during an asthma episode:

1. Give Emergency Asthma medications: (parents must provide meds to school)
   a. **Bronchodilator** (quick-relief medication)
      i. Name: ____
      ii. Purpose: ____
      iii. Dosage: ____
      iv. When to use: _____________________________________

   Can be repeated for severe breathing difficulty ________ times _________ minutes apart.
   Call 911 or EMS if minimal or no improvement.

   b. Other medications:
      i. Name: ____
      ii. Purpose: ____
      iii. Dosage: ____
      iv. When to use: _____________________________________

Physician Authorization for Asthma Self-Care:

☐ I have instructed this student in the procedure to use his/her asthma medication and it is my professional opinion that this student **SHOULD** be allowed to carry and self-administer the medication while on school property or at school-related events. This student has my permission to self-administer the medication as directed above, on a properly labeled container, at the times and dosages indicated above.

☐ It is my professional opinion that this student **SHOULD NOT** carry or self-administer his/her asthma medications while on school property or at school related events.

Physician signature: ____ Date: _____________________

Physician office number: ____________________________________

Both parts must be completed and returned to the school nurse before a student can carry asthma medication at school.