

SCHOOL ASTHMA ACTION PLAN

This plan is in accordance with new legislation, HB 1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from parents and physicians.

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's Name: _____ Grade: _____ DOB: _____
Teacher's Name: _____ School Year: _____
Parent/Guardian Name: _____ Home phone: _____
Address: _____ Work phone: _____
Emergency Contact _____

Name	Relationship	Phone
Physician student sees for asthma: _____		Phone: _____
Other physician: _____		Phone: _____

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that _____ (student's name) should be allowed to carry and self-administer the following medications while on school property or at school-related events:

A. Bronchodilator (Quick-relief medication):

Name: _____
Purpose: _____
Dosage: _____
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:

Name: _____
Purpose: _____
Dosage: _____
When to use: _____
Additional instructions: _____

These medications are prescribed for the time period _____ until _____

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.

Physician's Signature

Date

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events.

Parent/Guardian's Signature

Date

DAILY TREATMENT PLAN

Please list any medications taken daily to manage asthma, including nebulizer treatments.

Name	Purpose	Dosage	When to use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

These medications are prescribed for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.)

***** **EMERGENCY PLAN** *****

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 medications:

A. Bronchodilator (Quick-relief medication):

Name: _____

Purpose: _____

Dosage: _____ 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:

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. Seek emergency medical care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Student exhibits:
 - Chest and neck pulled in with breathing
 - Struggling to breathe
 - Stops playing and cannot start activity again
 - Hunched over while breathing
 - Trouble walking or talking
 - Lips of fingernails turn gray or blue

Comments and special instructions: _____

Physician's Signature

Date

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's Signature

Date