WALL ISD ASTHMA ACTION PLAN

(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: __________

All Current Medications

Name of Medication	Dosage	Time

Medications to be given at school:

*****IF THE INHALER DOES NOT HAVE PHARMACY LABEL – STUDENT MUST HAVE BOX WITH PHARMACY LABELAND CARRY BOX WITH INHALER*****

1. Name: ______________________________
   Purpose: ______________________________
   Dosage: ______________________________
   When to use: ______________________________
   Can be repeated for severe breathing difficulty __________times __________minutes apart.
2. Name: ______________________________
   Purpose: ______________________________
   Dosage: ______________________________
   When to use: ______________________________
   Can be repeated for severe breathing difficulty __________times __________minutes apart.

- Follow emergency plan if child shows any of the following symptoms:
  - Struggling to breathe, hunched over while breathing, chest retracting, trouble walking or talking, stops playing and cannot start activity again, or lips or fingernails turn gray or blue.

EMERGENCY PLAN

- Give rescue medication (bronchodilator) and repeat ______ times ______ minutes apart.
- If there is no or little improvement within 15 minutes after the first treatment call 911.

☐ I have instructed this student the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events:

☐ It is my professional opinion that this student should **NOT** be allowed to carry and/or 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.

______________________________ __________

Parent/Guardian's Signature Date

**** MUST BE SIGNED BY BOTH PARENT AND PHYSICIAN TO BE VALID

RETURN TO KIM ROLLWITZ RN SCHOOL NURSE- YOU MAY SCAN AND E-MAIL TO kim.rollwitz@wallisd.net