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:

o Chest and neck pulled in with breathing

o Hunched over while breathing

o Struggling to breathe

o Trouble walking or talking

o Stops playing and cannot start activity again

o Lips of fingernails turn gray or blue

Comments and special instructions: ____________________

____

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______________________________________ ____________

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*