

Bandera ISD School Asthma Action Plan

This plan is in accordance with HB 1688(2001). 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 in the school clinic.

Student Name: _____ Grade: _____ D.O.B. _____

Teacher's Name : _____ School Year: _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____ City: _____ Zip: _____

Parent/Guardian Phone Number (Home): _____ (Work): _____

Emergency Contact: _____ 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 _____ to _____.

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 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. (ie. spacer, nebulizer, oxygen, etc.)

Emergency Plan

Emergency action is necessary when this student has symptoms such as: _____

Steps to take during an asthma episode:

1. Give emergency medications:
 - a. Bronchodilator (quick relief medication) Call 911 or EMS if minimal or no improvement.
Name: _____
Purpose: _____
Dosage: _____
Can be repeated for severe breathing difficulty _____ times _____ minutes apart.
 - 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, stops playing and cannot start activity again, trouble walking or talking, struggling to breath, hunched over while breathing, or lips or fingernails turn gray or blue.

Comments or 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 my physician's instructions above.

Parent/Guardian Signature Date