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