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 carry and self-administer emergency rescue medication while at school or school functions with permission from parents, physician, and school nurse.

Student's Name: ____ Grade:_____________ DOB:____________________

Parent/Guardian

Name(s): ____ Home phone: ___________________________

Address: ____ Work phone: ___________________________

Emergency Contact

Name: ____ Relationship: __________ Phone: ____________________

Physician student sees for allergies/asthma: ________________________________ _______ Phone: _______________________

Administration of Asthma Medications at School

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY STATE OF TEXAS

Emergency rescue medication

Name: ____

Purpose: ____

Dosage: ____

When to use: ____

For asthma inhalers only Can be repeated for severe breathing difficulty ________ times_________ minutes apart.

Nebulizers

Name: ____

Purpose: ____

Dosage: ____

When to use: ____

Can be repeated for breathing difficulty ______________________ times ______________________minutes apart.

Additional Instructions: ____

These medications are prescribed for the time period ____________________ until ________________________

Call 911 or EMS if minimal or no improvement.

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

☐ **No.** It is my professional opinion that ________________________________ (student's name) **should NOT be allowed to carry** and self-administer any of his/her emergency rescue medication while on school property or at school related events.

____ _____________________

Physicians Signature Date

B. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

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 emergency rescue medication while on school property or at school-related events according to school district policy and the student agreement below.

____ ________________________________

Parent/Guardian's Signature Date

C. TO BE COMPLETED BY STUDENT AND SCHOOL NURSE

______ Student knows name, correct dosage, purpose, expected effects, and side effects of medication.

______ Student demonstrated correct use/administration of medication.

______ Student understands that medication must have prescriptions label affixed, that allowing anyone else to use this medication will result in disciplinary action, and that the PRIVILEGE of carrying this medication can be rescinded for violating any part of this agreement.

This signed agreement must be on file in the clinic.

_______________________________ ____ ________________________________

Student's Signature School Nurse's Signature Date