



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 severe breathing difficulty, inhaler may be repeated _____ times _____ minutes apart.

Nebulizers – EMERGENCY USE ONLY

Name: _____
 Purpose: _____
 Dosage: _____
 When to use: _____
 Can be repeated for breathing emergency _____ 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