SHERMAN INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH
SCHOOL ASTHMA ACTION PLAN

This plan is in accordance with new legislation, HB1688, 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 physicians and parents.

(2 pages to be completed at the beginning of each school year and kept on file with the school nurse)

School Year: ________

Student's Name: _________________________Grade/Teacher: _________________ DOB: _________________

Parent/Guardian: ____________________________ Home phone: _____________

Work phone: _____________ Cell phone: _______________

Physician student sees for asthma: ______________________________ Phone: _____________________

Other Physician: ____ Phone: _____________________

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS (To be filled out by physician)

Physician Please Check one:

☐ I have instructed ________________________(student's name) in the proper way to use his/her medications. It is my professional opinion __________________(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) - must have pharmacy label on inhaler.

Name: ____

Dosage: ____

Purpose: ____

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 - all other medications must have a pharmacy label.

Name: ____

Dosage: ____

Purpose: ____

When to use: ____

Additional instructions: ____

☐ 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 _______________________ **Phone** _______________ **Date** _____________

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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 medication taken daily to manage asthma, including nebulizer treatments:

	Name	***Purpose***	***Dosage***	***When to use***
1.	____________	____________	____________	____________
2.	____________	____________	____________	____________
3.	____________	____________	____________	____________

Medical Equipment:

Please list any medical equipment this student will need to treat his/her asthma at school(i.e. spacer, nebulizer, oxygen, etc.).

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****************************EMERGENCY PLAN ***********************

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

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (Quick-relief medication):

Name: ____

Purpose: ____

Dosage: ____

B. Other medications:

Name: ____

Purpose: ____

Dosage: ____

***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, hunched over while breathing, struggling to breathe, trouble walking or talking, stops playing and cannot start activity again, or lips or fingernails turn gray or blue.

Comments and special instructions: ____

Physician's Signature ______________________**Phone** ___________________**Date** ________________

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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** _____________________