

PLANO INDEPENDENT SCHOOL DISTRICT

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.

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

Student's Name: _____ DOB: _____

Father: _____ H: _____ W: _____ Cell: _____

Mother: _____ H: _____ W: _____ Cell: _____

Physician student sees for asthma: _____ Phone: _____

Other Physician: _____ Phone: _____

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

Physician Please Check one:

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.

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) - must have pharmacy label on actual plastic 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: _____

Physician's Signature _____ **Phone** _____ **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's Signature _____ **Date** _____

(continued on next page)

ASTHMA ACTION PLAN continued

DAILY TREATMENT PLAN AND EMERGENCY PLAN

Please list any medication taken daily to manage asthma, including nebulizer treatments:

	<i>Name</i>	<i>Purpose</i>	<i>Dosage</i>	<i>When to use</i>
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.). *Parent will provide equipment needed.*

BEST PEAK FLOW _____

Treatment if peak flow in Green Zone (*peak flow between 80-100% of personal best*):

Treatment if peak flow in Yellow Zone (*peak flow between 50-80% of personal best*):

Treatment if peak flow in Red Zone (*peak flow less than 50% of personal best*):

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

- 1. _____ 3. _____
- 2. _____ 4. _____

Seek emergency medical care if this student experiences any of the following:

- a. No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
- b. 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** _____

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** _____