ALDINE INDEPENDENT SCHOOL DISTRICT
14910 Aldine-Westfield Road • Houston, Texas 77032-3099 • (281) 449-1011

SCHOOL 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 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 with the school nurse or office of the principal)

Student's Name:_____ Grade:_____ DOB:_____

School Campus:_____ School Year:_____

Parent/Guardian Name:_____ Home phone:_____

Address: _____ Work phone:_____

Emergency Contact_____

Name Relationship Phone

Physician student sees for asthma: _____ Phone:_____

Other physician: _____ Phone: _____

SELF-ADMINISTRATION OF ASTHMA 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:

He/She has been instructed in the proper way to use his/her medications.

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 _____until _____

☐ It is my professional opinion that _____(student's name) should **NOT** be allowed to carry and self-administer any of his/her asthma medications as listed above 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 or** ☐ **may not** 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 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 (i.e. spacer, nebulizer, oxygen, etc.)

_____

_____

* EMERGENCY PLAN *

Emergency action for an asthma episode using medications listed below is necessary when this student has symptoms such as:

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

Steps to take during an asthma episode:

1. Give emergency medications:

   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 _____ 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
Lips or fingernails blue or gray	Difficulty walking or talking
Difficulty breathing	Hunched forward to breath

Comments and 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 physician's instructions above.

_____

Parent/Guardian's Signature *Date*

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SCHOOL ASTHMA ACTION PLAN

Este plan está en conformidad con la nueva legislación, HB 1688, la cual pasó durante la Sesión Legislativa de Texas del 2001. Este proyecto de ley les permite a los estudiantes que con el permiso de los padres y de los médicos se administren ellos mismos los medicamentos para el asma mientras estén en la escuela o asistiendo a funciones escolares.

(Debe ser completado al principio de cada año escolar y guardado en la oficina de la enfermera o del director de la escuela)

Nombre del Estudiante:_____ Grado:_____ Fecha de Nacimiento:_____

Escuela:_____ Año Escolar:_____

Nombre del Padre/Guardián:_____ Teléfono de la Casa:_____

Dirección:_____ Teléfono del Trabajo:_____

Contacto en Caso de Emergencia_____

Nombre Relación Teléfono

Doctor que ve al estudiante para el asma:_____ Teléfono:_____

Otro Doctor:_____ Teléfono: _____

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

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He/She has been instructed in the proper way to use his/her medications.

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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 _____until _____

☐ It is my professional opinion that _____(student's name) should **NOT** be allowed to carry and self-administer any of his/her asthma medications as listed above while on school property or at school related events.

_____ _____

Physician's Signature Date

Yo estoy de acuerdo con las recomendaciones del doctor de mi hijo/a escritas arriba y le he informado a mi hijo/a de que él/ella ☐ **puede o** ☐ **no puede** llevar consigo y auto-administrar sus medicamentos para el asma mientras esté en la escuela o en eventos relacionados con la escuela.

_____ _____

Firma del Padre/Guardián Fecha

DAILY TREATMENT PLAN

Please list any medications taken daily to manage asthma, including nebulizer treatments.

Name	*Purpose*	*Dosage*	*When to use*
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These medications are prescribed for the time period _____ until _____

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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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Chest and neck pulled in with breathing	Stops playing and cannot start activity again
Lips or fingernails blue or gray	Difficulty walking or talking
Difficulty breathing	Hunched forward to breath

Comments and special instructions: _____

_____

_____

Physician's Signature *Date*

Yo le doy permiso a la escuela de mi hijo/a para administrar medicamentos de emergencia como sean necesarios, de acuerdo con las instrucciones del doctor dadas arriba.

_____

Firma del Padre/Guardián *Fecha*