WILLS POINT INDEPENDENT SCHOOL DISTRICT
Health Services

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.

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

Teacher's Name:_____ 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

☐ 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:

_____ _____

Physician's Signature Date

A. Bronchodilator (Quick-relief medication): **PEAK FLOW BASELINE** _____

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 _____ **(New orders are required each school year.)**

☐ 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 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

Return to: Felicia Brinkley, RN High School Nurse, Wills Point High School, 1800 W S Commerce Wills Point, TX 75169
(Phone) 903-873-5154 (Fax) 903-873-6008

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 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: _____ 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 _____ **(New orders are required each school year.)**

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	○ Struggling to breathe	○ Stops playing and cannot start activity again
○ Hunched over while breathing	○ Trouble walking or talking	○ Lips of fingernails turn gray or blue

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. My child will not carry the medication.

Parent/Guardian's Signature_____ Date_____