# ROUND ROCK INDEPENDENT SCHOOL DISTRICT
## Health Services Department
## 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 parents and physicians. This document is 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: ________________

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 this student 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):

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:

Medication Name: ____________________________________________

Purpose: ____________________________________________

Dosage: ____________________________________________

When to Use: ____________________________________________

Additional Instructions: ____________________________________________

These medications are prescribed for the time period of __________________ 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 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

**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 of ___________________ 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):

      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:

      Medication Name: _____________________________________________________

      Purpose: ___________________________________________________________

      Dosage: ____________________________________________________________

      When to Use: ________________________________________________________

      Additional Instructions: _______________________________________________

   These medications are prescribed for the time period of _________________ until _________________.

2. 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. If student exhibits any of the following symptoms:
      - Chest and neck pulled in with breathing
      - Struggling to breathe
      - Hunched over while breathing
      - Lips or fingernails turn gray or blue
      - Stops playing and cannot start activity again
      - Trouble walking or talking

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