

**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:**

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 his/her \_\_\_\_\_ (name of inhaler) inhaler while on school property or at school-related events. His/her parents are aware that there will not be an inhaler available in the school clinic unless they decide to provide an extra 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. It should be kept in a designated area (i.e. school clinic) and be accessible to the student.

**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*):

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

- \_\_\_\_\_
- \_\_\_\_\_

***Triggers (what causes symptoms):***

- \_\_\_\_\_
- \_\_\_\_\_

***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:*** \_\_\_\_\_

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**Physician's Signature** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Date** \_\_\_\_\_

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I agree with the recommendations of my child's physician as noted above and agree that this form is not complete without the physician's signature above.

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_