Asthma Management Plan

Abernathy ISD 2018-2019

505 7th Street, Abernathy, TX 79311

Student: ____ Date of Birth: ____________________________

Allergies: ____________________________ Teacher: __________________________ Grade/Room: ____________

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Asthma Triggers: (Check each that applies to the student)

______Exercise	______Animals	______Emotions/stress	______Pollens
______Respiratory infections	______Smoke, odors or fumes	______Change in temperature	______Molds
______Carpets in room	______ Food _____________	______Other ______________	______Chalk dust

Student's Daily Medications: (Please list all medications administered at home and at school-include nebulizer treatments)

________________________ ________________________ ________________________

________________________ ________________________ ________________________

I request that this School Asthma Management Plan be implemented for my child according to the signed protocol below for my child's physician. I hereby give my permission for the school nurse to consult with the prescribing physician regarding these orders.

Parent/Guardian Signature: ____ Date: __________________

Emergency Phone Numbers: ____

TO BE COMPLETED BY PHYSICIAN:

<u>EMERGENCY ACTION</u> is necessary when this student has symptoms such as:

1. Wheezing   2. Cough   3. Tight Chest   4. Difficulty Breathing   5. Coughing at Night

STEPS to take during an asthma episode:

1. Give Emergency Asthma Medications: (Parents must provide medications to school)

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: ____

PHYSICIAN AUTHORIZATION FOR ASTHMA SELF-CARE:

☐ I have instructed this student in the procedure to use his/her asthma medication and it is my professional opinion that this student **SHOULD** be allowed to carry and self-administer the medication while on the School property or at school-related events. This student has my permission to self-administer the medication as directed above, on a properly labeled container, at the times and dosages indicated above.

☐ It is my professional opinion that this student **SHOULD NOT** carry and self-administer his/her asthma medications while on School property or at school related events.

Printed Name of Physician: ____ Date: ______________

Physician's Signature: ____

Physician's Office Number ____ FAX: _______________________

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Abernathy ISD

2018-2019

To be completed only if the student has asthma

If your child has asthma, Abernathy ISD is requesting an Asthma Management Plan for your child for the school year of 2018-2019. Please take the following form to your physician/clinic for them to complete so that we may have an asthma plan on file for your child and so that we may treat your child for asthma according to the plan.

Thank you,

Nurse Tawnya

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(806)298-4932

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