Academy ISD Health Services
Parent Authorization for Asthma Emergency Plan

Campus:

Student	DOB	Grade/HR	Rides Bus #

Age asthma diagnosed: ________

☐No ☐Yes Student has had an asthma attack in the last 3 months that required an emergency room visit

☐No ☐Yes Student has known triggers that should be avoided. If yes, list:

____

☐No ☐Yes Student permitted to carry & self administer their inhaler

☐No ☐Yes Student understands when to limit physical activity

☐No ☐Yes Student knows when & how to tell an adult they may be having an asthma attack

List asthma medications taken at home:

Medication required at school: Dosage/Route/Times	Pharmacy/RX #	Expiration Date

Specific medication instructions/ precautions/ side effects on your child:

Medication will be kept at school:
☐N/A ☐In health office ☐Student will carry in/on ____________________ ☐Other: ____________________

Please review standard emergency care at school and add additional instructions as needed.

If you see this:	Do this:
• **Student complains of shortness of breath** • **Wheezing** • **Persistent coughing** • **Tightness in the chest** • ______________________	• **Stop activity** • ****Student Needs their asthma medication** • **Call the nurse/ office for assistance** • **Sit student up in comfortable position** • **Stay with student- DO NOT LEAVE ALONE** • **Encourage drinking water to thin mucus (warm water best if available**
• **Asthma symptoms do not improve with medication**	• **May repeat inhaler ________puffs, __________times or every________min. up to one hour if symptoms persist or worsen. (See below)**
If You See Any Of These SEVERE SYMPTOMS: • **Difficulty talking due to shortness of breath** • **Student becomes very anxious** • **Using neck muscles when breathing** • **Gasping for air** • **Pale or bluish tint around mouth/face/fingertips**	• **Call or have someone CALL 911/ then call nurse/principal/parent** • **Continue to assist student with their asthma medication as directed above** • **Start CPR if indicated** • **Additional instructions:**

PHYSICIAN/PARENTAL AUTHORIZATION FOR EMERGENCY PLAN FOR ASTHMA

Physician authorization: Print Name	Physician Signature	Physician Phone	Date

I grant permission to Academy ISD to administer this medication to my child. I am giving permission to AISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may give the medication.

☐ I request that my child be permitted to carry their inhaler on their person in school and use in case of an asthma attack

Parental Authorization: Signature	Best emergency phone	Other phone	Date
Emergency Contact	Phone	Other phone	

School Use Only

Completed by:	Date	Teachers notified	Rides Bus #

Staff use only: Document administration of medication below and/or in student's electronic health record

Date	Time	Signature	Print Name	Comments