Dickinson ISD **Asthma Action Plan**

Special Programs **Health Services**

Student Name: _____ DOB: _____ Grade/Teacher: _____

Student has the following triggers which cause asthma episodes (check all that apply):

- ☐ Exercise
- ☐ Respiratory infection
- ☐ Change in Temperature
- ☐ Animals
- ☐ Foods
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Pollens
- ☐ Molds
- ☐ Other

Pertinent Medical History other than asthma:

_____
_____
_____
_____
_____

Daily **Home** Medication:

Name	Dose	Time	Frequency
1.			
2.			

EMERGENCY PLAN:

1. Send student to nurse at onset of symptoms for assessment and treatment. If severe, escort student to the nurse for assessment and medication administration as required.
2. Contact parent/guardian either by phone or send note home depending on severity.
3. **Call 911.** Seek emergency medical care if the student has any of the following:
   - ☐ No improvement 15-20 minutes after initial treatment with medication and a parent/guardian cannot be reached.
   - ☐ Symptoms of respiratory distress. **Oxygen saturation below:** _____

     Difficulty or discomfort when breathing *Nasal flaring*
     Chest and neck pulled in when breathing *Student is hunched over*
     Trouble walking or talking *Lips or fingernails are gray or blue*

   - ☐ Other: _____

DISD staff will **administer the medication(s)** as prescribed, **call 911 for severe symptoms that do not improve with medication**, and **notify parents** of action plan initiation.

MEDICATION AND DOSAGE:

	RESCUE INHALER (spacer ☐Yes ☐No)	**NEBULIZER TREATMENT**
NAME OF MEDICATION:		
WHEN TO GIVE MEDICATION:		
DOSAGE:		
FREQUENCY:		
MAY REPEAT:	**_____times in _____minute intervals**	**_____times in _____minute intervals**

SELF-ADMINISTRATION

To be completed by prescribing healthcare provider (HCP) only. I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

- ☐ **allowing student self-transport/administration of his/her rescue inhaler for the current school year. During my assessment the student verbalized the purpose of the medication, the time/circumstance to administer, and when to seek help from school staff.**
- ☐ **restricting permission to self-transport/administer his/her rescue inhaler and reevaluating permission at a later date.**
- ☐ **other:**

_____ _____ (____) ____- _____ ____/____/20____

Printed name of HCP Signature of HCP Phone number Date

I agree with the recommendations of my child's HCP and authorize DISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate DISD employees for the current school year.

_____ _____ (____) ____- _____ ____/____/20____

Printed name parent/guardian Signature parent/guardian Phone number Date