Student's Name:_____ DOB: _____
Parent Name: _____ Contact Number: _____

KAUFMAN ISD
School Asthma Quick Relief and Emergency Plan

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe Cough	Shortness of Breath	Sucking in the chest wall	Decreased or loss of consciousness
Chest Tightness	Turning Blue	Shallow, rapid breathing	Difficulty Talking
Wheezing	Rapid, labored breathing	Difficulty Walking	Blueness of fingernails and lips

Steps to Take During an Asthma Episode:

1. Give Emergency Medications as Listed Below:

Quick Relief Medications	Dose/Frequency	When to Administer
1.		
2.		

2. **Contact Parents if**_____
3. **Call 9-1-1** to activate EMS if the student has ANY of the following:
   - **Lips or fingernails are blue or gray**
   - **Student is too short of breath to walk, talk, or eat normally.**
   - **No relief from medication within 15-20 minutes with any of the following:**
     - **Chest and neck pulling in with breathing**
     - **Child is hunching over.**
     - **Child is struggling to breath**

A. TO BE COMPLETED BY PHYSICIAN LICENSED BY THE STATE OF TEXAS:

I have instructed student above in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry, and self-administer the above rescue medication while on school property or at school-related events.

PHYSICIAN SIGNATURE:_____ Date:_____

Student will carry/keep medication: _____
(Specify location)

____Student knows name, correct dosage, purpose, expected effects, and side effects of medication.

____Student demonstrates correct use /administration of medication

____Student understands that allowing someone else to use this medication will result in disciplinary action, and that the PRIVILIGE of carrying this medication can be rescinded for violating any part of this agreement.

Student Signature: _____ Date: _____

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

- Provide necessary supplies and equipment.
- Notify the school nurse of any changes in student's health status.
- Notify the school nurse and complete new consents for changes in orders from the student's health care provider.
- Authroize the school nurse to communicate with child's PCP.
- School staff interacting directly with my child may be informed about his/her asthma plan, and needs of student.

Parent Signature:_____ **Date:** _____
Reviewed by School Nurse: _____ **Date:**_____

Student's Name:_____ DOB: _____
Parent Name: _____ Contact Number: _____