



Carroll ISD Health Services
Parental Authorization for Asthma Action Plan

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name: _____ D.O.B.: _____ Grade/Teacher: _____
 Parent/Guardian: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____
 Transportation: Car rider Walker Drives self Rides bus # _____
 Before/After school activities: Athletics Band Club: _____ Tutoring Other _____

Asthma History

At what age was student diagnosed with asthma/reactive airway disease? _____
 Has student had an asthma attack in the last 3 months that required an Emergency room visit? NO YES

Asthma Triggers: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Viral infection (cold, flu, sinus, bronchitis) | <input type="checkbox"/> Seasonal allergies/pollen: _____ |
| <input type="checkbox"/> Exercise/sports | <input type="checkbox"/> Other allergens (dust mites, animal dander/fur, feathers) |
| <input type="checkbox"/> Hot or cold temperatures | <input type="checkbox"/> Environmental irritants (smoke, perfume, aerosols, dust, paint, odors) |
| <input type="checkbox"/> Stress, anxiety, strong emotions | <input type="checkbox"/> Other: _____ |

Asthma Symptoms: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Anxious, fearful, strong emotions |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Pale face/lips | <input type="checkbox"/> Retraction of chest muscles |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rapid, shallow breathing | <input type="checkbox"/> Other: _____ |

List any preventative medication taken at home on a regular basis:

List any emergency or "as needed" medication taken at home (*inhaler or nebulizer for example*):

Does student require Peak flow monitoring? NO YES Personal Best Number: _____

Management of an Acute Asthma Episode in School

If student has wheezing, shortness of breath, chest tightness, excessive coughing, rapid breathing or exaggerated intake of air in an effort to fill lungs:

- Stop activity and get student into a comfortable position.
- Speak calmly and reassuringly to student. Encourage slow deep breathing.
- Escort student to clinic or call nurse immediately for onsite assistance. Never leave student alone.
- If available, administer prescribed medication by inhaler or nebulizer. If student carries an inhaler, assist with administering inhaler as soon as possible. Student should respond to treatment within 15-20 min.
- If medication is ineffective and/or student show signs of distress, call 911 to activate emergency services. Signs of distress include:
 - Labored breathing with flaring of nostrils, gasping or grunting when breathing in
 - Breathing becomes hard and fast and student is hunched over or ribs are visible when trying to take a breath
 - Student appears exhausted, pale, or lips/fingertips begin to turn blue
 - Student can no longer talk or becomes unconscious or stops breathing.
- Notify parent or guardian

Other _____

Medication at School

Will student have rescue medication at school? NO YES*

If yes, check all that apply: ___ Inhaler ___ Nebulizer ___ Epinephrine

* A medication administration form is required for all prescription medications. This form can be found on the Carroll ISD website under the Department of Health Services, Medication & Health Forms.

Does student need to pre-medicate before PE/athletics/recess? NO YES, always YES, as needed

For intermediate through high school students, will student self-carry and self-administer his/her inhaler?

NO YES If yes, complete Self-Administered Inhaler section below.

Parent Instructions for Self-Carry and to Self-Administer Inhaler at School

For parents of students in grades 5-12, please initial one of the following statements:

_____ My child, _____, has been instructed in the proper way to use his/her inhaled medication. (See Student Contract below.) My student should be allowed to carry & use his/her own inhaled medication. **It is advisable to keep a second inhaler in the nurse's office.*

_____ It is my opinion that my student should not be allowed to carry or use his/her own inhaled medication. Please assist my student with medication if signs or symptoms of respiratory difficulty present.

Intermediate through High School Student Contract for Self-Carry & to Self-Administer Inhaler at School

By initialing each statement & signing below, the student indicates their understanding and agreement with the following statements:

_____ I know how and when to use my inhaler and have discussed this with my doctor.

_____ I know it is my responsibility to keep my inhaler with me where it is easily accessible in case I need it during school hours, extracurricular activities, and field trips.

_____ I will notify the school nurse or a responsible school adult if I have used my inhaler and it is not working for me or if my symptoms return before I am supposed to use my inhaler again.

_____ I will notify the school nurse or my parents if my inhaler is lost, stolen or expired.

_____ I will not share my inhaler with anyone else.

_____ I understand that a "back up" inhaler in the nurse's office is advisable.

Student Signature

Date

Parental Authorization

I grant permission to Carroll ISD to follow the above Action Plan for my child and to take whatever measure in their judgement may be necessary to provide emergency medical services consistent with this Action Plan, including the administration of medication to my child. I give permission to Carroll ISD to contact my physician for additional information as necessary. I grant the school nurse permission to share this Action Plan with my student's teacher(s). I also authorize Carroll ISD staff members to share the contents of my child's Action Plan with chaperones and other volunteers at school events or field trips as necessary to ensure the safety and well-being of my child.

Parent/Guardian Signature

Date

Updated 5/11/20