

**Silsbee Independent School District
Asthma Action Plan**

Student Name: _____

School Year: _____

Administration of Asthma Medications: Peak Flow Goal: _____ to _____

A. Bronchodilator (Quick-relief medication): _____

Purpose: _____

Dosage: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other medications: _____

Purpose: _____

Dosage: _____

Additional instructions: _____

Seek emergency medical care (911 or EMS) if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medications and a relative cannot be reached.
- Student exhibits:

Chest and neck pulled in with breathing	Stops playing and cannot resume activity
Hunched over while breathing	Lips and fingernails turn gray or blue
Struggling to breathe	Trouble walking or talking

Comments and special instructions: _____

____ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the following medications while on school property or school-related events.

____ Student is to notify his/her teacher or nurse after using inhaler.

____ It is my professional opinion that _____ (student's name) should **NOT** be allowed to carry and self-administer any of his/her medications, but all medications should be kept and administered by a responsible adult while on school property or at school-related events.

Physician's Signature _____ Date _____

____ I agree with the recommendations of my child's physician as noted above and have informed my child of what he/she should do in the event of an asthma episode.

Parent/Guardian Signature _____ Date _____