Cedar Hill ISD Health Services
ASTHMA ACTION PLAN

Name of Student: _____ **DOB:** _____ **Grade:** _____

Physician ordering medication: _____ **Phone:** _____ **Fax:** _____

** All medication must be received in its original container and properly labeled by the pharmacy to be kept at school and/or carried by the student.

FOR THE PHYSICIAN

Asthma Severity: ☐ **Mild** ☐ **Moderate** ☐ **Severe** **Asthma Control:** ☐ **Well-Controlled** ☐ **Not-Controlled**

Asthma Medication	Method i.e. inhaler, spray, Nebulizer	Dosage	Frequency	Length of time
1.				
2.				
3.				

EMERGENCY PLAN:

- _____ can be repeated for **severe** breathing difficulty _____ times _____ minutes apart.
  Medication
- **Call parent/legal guardian and/or 911(EMS) or both if minimal or no improvement.**

Please check all that apply:

☐ ***It is my professional opinion that _____ (student's name) ☐ should ☐ should NOT be allowed to carry and self-administer any of his/her asthma medications while on school property and/or at school related events.***

☐ ***Student has been properly instructed on the correct way to self-administer the asthma medication(s).***

☐ ***Student is knowledgeable about his/her medical condition, the medication(s) to be taken and has properly demonstrated the ability to correctly administer the medication and follow his/her medical plan.***

I AUTHORIZE THE MEDICATION LISTED ABOVE BE KEPT AT SCHOOL FOR THE ENTIRE SCHOOL YEAR AND BE GIVEN AS WRITTEN ABOVE.

_____ **Physician's Printed Name** _____ **Physician's Signature** _____ **Date**

FOR THE PARENT/GUARDIAN

I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips or other school sponsored activities as prescribed.

I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s) (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's asthma.

I give permission for the school nurse to consult with the above named student physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s).

I along with my child's physician, give my permission for him/her to carry their inhaler at school ____ yes ____ no _____(initial)

_____ **Parent's Printed Name** _____ **Parent's Signature** _____ **Date**

FOR OFFICE USE ONLY

Medication started: _____
Medication stopped: _____
Medication returned to student/parent: _____

Physician's Office Stamp

Aug ___ Jan ___
Sept ___ Feb ___
Oct ___ Mar ___
Nov ___ April ___
Dec ___ May ___

Revised 5/19