Cypress-Fairbanks Independent School District

Health Services: Asthma Action Plan

Name: _____ Student ID: _____ DOB: _____/_____/_____

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

MEDICATION(S)/TREATMENT

To be completed by prescribing healthcare provider (HCP) only.

Prescribed medication for use at school:

_____
(Include dose, time, and route)

Quick relief medication:

☐ _____ puffs of _____ (MDI)
Q _____ hours as needed for:

☐ Coughing ☐ Chest Tightness

☐ Retractions/Nasal flaring

☐ Wheezing ☐ SpO2 ≤_____%

☐ Repeat _____ times _____ minutes apart for persistent symptoms

Physical Activity:

☐ ____ puffs before physical activity

Post Illness/exacerbation:

☐ _____ puffs of _____ (MDI)
Q _____ hours for _____ days with written parent consent (updated MD order required beyond above specified days)

Nebulizer treatment:

☐ _____ vials of _____
Q _____ hours as needed for:

☐ Coughing ☐ Chest Tightness

☐ Retractions/Nasal flaring

☐ Wheezing ☐ SpO2 ≤_____%

☐ Repeat _____ times _____ minutes apart for persistent symptoms

☐ Other: _____

_____
(Include dose, time, and route)

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 quick relief MDI 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 quick relief MDI and reevaluating permission at a later date.

☐ other: _____

ASTHMA FIRST AID

- Stay calm and contact the school nurse
- Escort person to nurse if able to walk
- Activate Emergency Action Plan
- Ensure upright positioning (to expand lung capacity)
- Administer medication as prescribed
- Remain with student

CALL EMS IF:

- [X] Person becomes unresponsive/unconscious
- [X] Lips or fingernails appear blue
- [X] Person is struggling to breathe (breathing hard and fast)
- [X] Can't speak due to difficulty breathing
- ☐ SpO2 ≤_____%

_____	_____	(_____) _____-_____	_____/_____/20_____
Printed name of HCP	Signature of HCP	Phone number	Date

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

_____	_____	(_____) _____-_____	_____/_____/20_____
Printed name, parent/guardian	Signature parent/guardian	Phone number	Date

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