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: _____

Revised 5/19

Physician's Office Stamp

Aug ___ Jan ____
Sept ___ Feb ____
Oct ___ Mar____
Nov ___ April____
Dec ____ May ____