

Waller Independent School District

Health Services: Asthma Action Plan

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

WISD staff will **administer medications** as prescribed and **call 911** for severe symptoms that do not improve with medication.

MEDICATION(S) / TREATMENTS	SELF - ADMINISTRATION
To be completed by prescribing healthcare provider (HCP) only	
Prescribed Medication for use <u>at school</u>: _____ (Include dose, time, and route) Quick Relief Medication: ☐ _____ puffs of _____ (MDI) every _____ 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 (within quick relief time parameters) Post Illness/Exacerbation: ☐ _____ puffs of _____ (MDI) every _____ hours for _____ days with written parent consent (updated MD order required beyond above specified days) Nebulizer Treatment: ☐ _____ vials of _____ every _____ hours as needed for: ☐ Coughing ☐ Chest Tightness ☐ Retractions/Nasal flaring ☐ Wheezing ☐ SpO2 ≤ _____ % ☐ Repeat _____ times _____ minutes apart for persistent symptoms Other: _____	I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend: ☐ allowing student self-transport/administration of inhaler 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 inhaler. Medications will be stored in school clinic. ☐ 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:
	☒ Person becomes unresponsive/unconscious ☒ Lips or fingernails appear blue ☒ Person is struggling to breathe (breathing hard/fast) ☒ Can't speak due to difficulty breathing ☐ SpO2 ≤ _____

Printed name of HCP Signature of HCP Phone number Date ____/____/____

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

Parent/Guardian Name Signature Phone number Date ____/____/____