School Asthma Action Plan

CONROE
INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Student Information

____
Student's name

______ ________________ ____________________
Grade School year Date of birth

____
Teacher's name

____
Parent's/Guardian's name

____
Parent's/Guardian's address

____
Parent's/Guardian's home phone

____
Parent's/Guardian's work phone

____
Emergency contact name

____
Emergency contact relationship

____
Emergency contact phone number

____
Physician student sees for asthma

____
Physician's phone number

____
Other physician

____
Other physician phone number

Self-Administration of Asthma Medications

Bronchodiliator *(quick-relief medication)*

____
Name of medication

____
Purpose of medication

____
Dosage of medication

____
When to use medication

Can be repeated for severe breathing difficulty

________ times ________ minutes apart.

Call 911 or EMS if minimal or no improvement.

Other medication

____
Name of medication

____
Purpose of medication

____
Dosage of medication

____
When to use medication

____
Additional instructions

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

☐ It is my professional opinion that *(student's name)* ______________________________ **should *not* be allowed** to carry and self-administer the following medications while on school property or at school-related events.

______________________________ ________________
Physician's signature *Date*

I agree with the recommendation of my child's physician as noted and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events.

______________________________ ________________
Parent's signature *Date*