Campus: _____ School Year: _____

Academy ISD Health Services Parent Authorization for Asthma Emergency Plan

Student	DOB	Grade/Homeroom	Rides Bus #

Age asthma diagnosed: _____

☐No ☐Yes Student has had an asthma attack in the last 3 months that required an emergency room visit

☐No ☐Yes Student has known triggers that should be avoided. If yes, list:

☐No ☐Yes Student is permitted to carry & self-administer their inhaler

☐No ☐Yes Student understands when to limit physical activity

☐No ☐Yes Student knows when & how to tell an adult they may be having an asthma attack

List asthma medications taken at home:

Medication required at school: Name/Dosage/Route/Times	Pharmacy/RX #	Expiration Date

Specific medication instructions/precautions/side effects on your child

Medication will be kept at school:

☐ N/A ☐ In health office ☐Student will carry in/on_____ Other_____

Please review standard emergency care at school and ADD ADDITIONAL INSTRUCTIONS as needed

IF YOU SEE THIS:	DO THIS:
• Student complains of shortness of breath • Wheezing • Persistent coughing • Tightness in chest • _____	• Stop activity • **student needs their asthma medication** • Call nurse/office for assistance • Sit student up in comfortable position • Stay with student – DO NOT LEAVE ALONE • Encourage drinking water to thin mucus (warm water best if available)
• Asthma symptoms do not improve with medication	• May repeat inhaler _____**PUFFS**, _____**TIMES** or every _____**MINS**. Up to one hour if symptoms persist or worsen (see below)
If you see any of these SEVERE SYMPTOMS: • Difficulty talking due to shortness of breath • Student becomes very anxious • Using neck muscles when breathing • Gasping for air • Pale or bluish tint around mouth/face/fingertips	• Call or have someone **CALL 911**/ then call nurse/principal/parent • Continue to assist student with their asthma medication as directed above • Start CPR if indicated • Additional instructions:

Physician/Parental authorization for ASTHMA EMERGENCY PLAN

☐Yes ☐No The above-named student has asthma and is capable of possession and self-administration of prescribed asthma medication(s) while at school and school-related events.

Authorizing Physician: (print)	Physician signature:	Date:

Additional Comments:	Physician Phone:

I grant permission to Academy ISD to administer this medication to my child. I am giving permission to AISD staff to contact my physician for additional information as necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may give the medication. I understand that, per Texas Education Codes 38.015 & 22.052, it is my responsibility to submit a physician/provider signed statement permitting the student to self-carry [if physician does not authorize & sign this form] and a parent/guardian-signed medication administration form [a separate, additional document].

☐ **I request that my child be permitted to carry their inhaler on their person in school/at school-related events/activities and to use it as indicated.**

Parental authorization: (print & sign)		Date:

Parent Email:	Best emergency phone:	Other phone:

Emergency Contact:	Phone:	Other phone:

SCHOOL USE ONLY (below this line)

Received By: (print & sign)	Date:	Teachers notified	Rides Bus #

Campus Nurse: (print & sign) I have reviewed and understand this form. I feel competent to execute this Asthma Emergency Plan.	☐ RN ☐ LVN ☐ other	Initial	Date:
Supervising RN: (print & sign) I have reviewed this form and delegate the execution of this Asthma Emergency Plan to the above-named individual.		Initial	Date:

CAMPUS NURSES: if medication is indicated, you MUST have a medication administration form SIGNED BY GUARDIAN prior to administration. Document administration of medication on BOTH the form and the Electronic Health Record. Update yearly. _____ initial _____ initial

Staff Notes

(document parent contact, clarification, indicate additional forms, etc.)