

***Cypress Fairbanks Independent School District  
Health Services***

Date: \_\_\_\_\_

Dear Parent of: \_\_\_\_\_,

The clinic records indicate that your child is asthmatic or had permission to carry and use an inhaler while at school during the \_\_\_\_\_ school year. If your child will be using an inhaler next school year, please take time this summer, to complete the paperwork enclosed. This paperwork must be submitted each school year in order to use an inhaler at school.

Once I have received the completed *School Asthma Action Plan* (enclosed), your child will be granted permission to carry and use the inhaler at school.

The physician must complete the *School Asthma Action Plan* and you must sign the bottom of both pages. You may have these forms faxed to the school clinic at \_\_\_\_\_ or deliver to the school clinic.

Please remember that inhalers are the only medication students may carry with them while at school. All other medications must be kept in the clinic. Please remind your child that inhalers are not to be shared and if breathing difficulties persist they must seek nursing assistance.

Thank you for preparing in advance for the opening day of school. Your time spent handling this matter will assist in a smoother start to a new school year. I look forward to seeing each of you in August.

Sincerely,

.  
School Nurse  
Clinic Phone: \_\_\_\_\_  
Clinic Fax: \_\_\_\_\_

# SCHOOL ASTHMA ACTION PLAN

This plan is in accordance with new legislation, HB 1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from parents and physicians.

*(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)*

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ School Year: \_\_\_\_\_

Parent/Guardian

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Emergency Contact

| Name | Relationship | Phone |
|------|--------------|-------|
|------|--------------|-------|

Physician student sees for asthma: \_\_\_\_\_ Phone: \_\_\_\_\_

Other physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

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:

A. Bronchodilator (Quick-relief medication):

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_

When to use: \_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_ times \_\_\_\_\_ minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other medications:

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_

When to use: \_\_\_\_\_

Additional instructions: \_\_\_\_\_

These medications are prescribed for the time period \_\_\_\_\_ until \_\_\_\_\_

It is my professional opinion that \_\_\_\_\_ (student's name) should **NOT** be allowed to carry and self-administer any of his/her asthma medications while on school property or at school related events.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

**DAILY TREATMENT PLAN**

Please list any medications taken daily to manage asthma, including nebulizer treatments.

| Name     | Purpose | Dosage | When to use |
|----------|---------|--------|-------------|
| 1. _____ | _____   | _____  | _____       |
| 2. _____ | _____   | _____  | _____       |
| 3. _____ | _____   | _____  | _____       |

These medications are prescribed for the time period \_\_\_\_\_ until \_\_\_\_\_

**Medical Equipment (Equipment must be provided by the parent)**

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*\*\* EMERGENCY PLAN \*\*\*\*\***

Emergency action is necessary when this student has symptoms such as:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Steps to take during an asthma episode:**

1. Give emergency medications:

A. Bronchodilator (Quick-relief medication):

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ When to use: \_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_ times \_\_\_\_\_ minutes apart.

**Call 911 or EMS if minimal or no improvement.**

B. Other medications:

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ When to use: \_\_\_\_\_

Additional instructions: \_\_\_\_\_

These medications are prescribed for the time period \_\_\_\_\_ until \_\_\_\_\_

**2. Seek emergency medical care if this student experiences any of the following:**

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Student exhibits:
  - Chest and neck pulled in with breathing
  - Struggling to breathe
  - Stops playing and cannot start activity again
  - Hunched over while breathing
  - Trouble walking or talking
  - Lips of fingernails turn gray or blue

Comments and special instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*\*\***

\_\_\_\_\_  
*Physician's Signature* \_\_\_\_\_  
*Date*

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

\_\_\_\_\_  
*Parent/Guardian's Signature* \_\_\_\_\_  
*Date*