Cypress-Fairbanks Independent School District

CFISD FOR ALL
OPPORTUNITY IS HERE.

Health Services: Asthma Action Plan

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

CFISD staff will **administer medication(s)** as prescribed, **call 911 for severe symptoms that do not improve with medication**, and **notify parents** of action plan initiation.

MEDICATION(S)/TREATMENT

Daily medication: _____
(include dose, time, and route)

[ ] _____puffs of MDI before exercise for _____ days with written parent consent (updated MD order required beyond above specified days)

Quick relief medication:
[ ] _____ puffs of _____
(MDI) Q _____ hours as needed for:

[ ] Coughing [ ] Chest Tightness

[ ] Retractions/Nasal flaring

[ ] Wheezing [ ] SpO2 ≤_____%

[ ] Repeat _____ times _____ minutes apart for persistent symptoms

[ ] Other: _____

_____
(include dose, time, and route)

CALL EMS IF:

[X] Person becomes unresponsive/unconscious

[X] Lips or fingernails appear blue

[X] Person is struggling to breathe (breathing hard and fast)

[X] Can't speak due to difficulty breathing

[ ] SpO2 ≤_____%

[ ] Other: _____

SELF-ADMINISTRATION

To be completed by prescribing healthcare provider (HCP) only.

I have assessed the student named above in appropriate medication administration. Based on my assessment, I recommend:

[ ] allowing student self-transport/administration of his/her quick relief MDI 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 his/her quick relief MDI and reevaluating permission at a later date.

[ ] 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

_____	_____	(_____) _____-_____	_____/_____/20_____
Printed name of HCP	Signature of HCP	Phone number	Date

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

_____	_____	(_____) _____-_____	_____/_____/20_____
Printed name, parent/guardian	Signature parent/guardian	Phone number	Date

Revised 9/2017

CFISD

Permission to Self-Transport/Administer Medication

Student Name: _____ ID#: _____ Grade: _____

With parent permission, a statement of the student's ability to self-transport/administer his/her medication from the prescribing medical provider, and a school nurse's evaluation, students in CFISD may self-transport/administer certain emergency medications. The medication must be transported in the **original container**, and the student should only carry a **daily dose of the medication**. The student is responsible to maintain his/her medication in an appropriate and accessible place at all times. The transport/use of undisclosed medications may result in disciplinary action according to the student code of conduct.

I, _____ [parent/guardian name], give permission to my son/daughter to transport and self-administer the medication(s) listed below while on a school campus. My child has demonstrated his/her understanding of proper medication use and understands that the medications listed below are not to be shared with others or taken in any way other than directed by the prescribing physician or manufacturer. I also understand that the misuse of medications can result in disciplinary action for my child according to the student code of conduct. On this form, I have disclosed all medications that my child is permitted to carry.

Parent Signature: _____ Date: _____/_____/20_____

I, _____ [student name], understand proper medication use and that the medication(s) listed below is only for my use during the school day. I will be responsible with my medication(s), take it only as directed by the prescribing physician or manufacturer, store them in a safe place in my belongings, and I will not share them with others under any circumstance. I also understand that the misuse or sharing of my medications can result in disciplinary action according to the student code of conduct. I will seek assistance from the school nurse or a responsible adult if I must administer an emergency medication(s) while at any CFISD school.

Student Signature: _____ Date: _____/_____/20_____

Medication 1: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

Medication 2: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

Medication 3: _____ Dose: _____ Route: _____
Reason for use: _____ Expiration date: _____/_____/20_____

For school nurse use only

I certify that the student named above:

Knows the name and purpose of the medication(s) he/she will self-transport	Yes / No
Knows the prescribed medication dose	Yes / No
Articulates the appropriate time and circumstance under which the medication(s) should be administered	Yes / No
Demonstrates the correct administration of the medication(s) listed above	Yes / No
Understands the period for which the medication(s) is/are prescribed	Yes / No

School Nurse Signature: _____ Date: _____/_____/20_____