

Exhibit 7: Sample Form for Self-Administration of Asthma Medication

Name of Student: _____

Name of Prescribing Provider: _____

Contact Information for Provider: _____

Description of condition/Reason for medication: _____

Prescribed medicine and dosage: _____

How/when medication should be used at school: _____

Anticipated length of treatment: _____

Parental/Provider Self-Administration Assessment and Consent

_____ (Name of Student) _____ has asthma, and is treated with prescription medication.

He/she is/is not (circle one) capable of administering their own medication, both on school grounds and at school-related events and activities. Any changes to the above medication, dosage or recommended regimen will be accompanied by an updated version of this consent.

(Parent/Guardian signature)

(Date)

(Healthcare provider signature)

(Date)

Exhibit 7

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 her/his 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.

Table with 4 columns: Name, Purpose, Dosage, When to use. Rows 1, 2, 3.

These medications are prescribed for the time period _____ until _____

Medical Equipment

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:
o Chest and neck pulled in with breathing o Struggling to breathe o Stops playing and cannot start activity again
o Hunched over while breathing o Trouble walking or talking o 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

Exhibit 7 (cont'd): Sample Form for Self-Administration of Asthma Medication

SCHOOL SELF-MANAGEMENT PLAN



Asthma and Allergy
Foundation of America
1125 15th St., N.W., Suite 502
Washington, DC 20005

**STUDENT ASTHMA
ACTION CARD**



Name: _____ Grade: _____ Age: _____

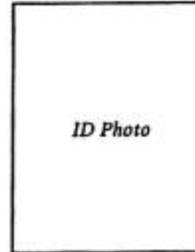
Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____



| | | | |
|----------------------------------|-------|--------------|-------|
| Emergency Phone Contact #1 _____ | _____ | _____ | _____ |
| | Name | Relationship | Phone |

| | | | |
|----------------------------------|-------|--------------|-------|
| Emergency Phone Contact #2 _____ | _____ | _____ | _____ |
| | Name | Relationship | Phone |

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

DAILY ASTHMA MANAGEMENT PLAN

• Identify the things which start an asthma episode (Check each that applies to the student.)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust | _____ |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Molds | |

Comments _____

• Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

• Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____

• Daily Medication Plan

| | Name | Amount | When to Use |
|----|-------|--------|-------------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

Figure 4-3.

SCHOOL SELF-MANAGEMENT PLAN (CONTINUED)

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____, _____, _____ or has a peak flow reading of _____.

• Steps to take during an asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if _____
3. Contact parent if _____
4. Seek emergency medical care if the student has any of the following:
 - ✓ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
 - ✓ Peak flow of _____
 - ✓ Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Child is hunched over
 - Child is struggling to breathe
 - ✓ Trouble walking or talking
 - ✓ Stops playing and can't start activity again
 - ✓ Lips or fingernails are gray or blue



IF THIS HAPPENS, GET EMERGENCY HELP NOW!

• Emergency Asthma Medications

| | Name | Amount | When to Use |
|----|-------|--------|-------------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

COMMENTS / SPECIAL INSTRUCTIONS

FOR INHALED MEDICATIONS

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

 Physician Signature

 Date

 Parent Signature

 Date