Cypress-Fairbanks Independent School District

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 _____
(metered dose inhaler) 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 2/2017