

SCHOOL ASTHMA ACTION PLAN

SAISD HEAD START/EARLY HEAD START

This plan is in accordance with HB 1688, which passed during the 2001 Texas Legislative Session.

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

Student's Name: _____ Center: _____ DOB: _____

Teacher's Name: _____ Room #: _____ School Year: _____

Parent/Guardian

Name: _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact

Name	Relationship	Phone
Physician student sees for asthma: _____		Phone: _____
Other physician: _____		Phone: _____

All Current Medications

Name of Medication	Dosage	Time

Medications to be given at school:

1. Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

2. Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

- Follow emergency plan if child shows any of the following symptoms:

- Struggling to breathe, hunched over while breathing, chest retracting, trouble walking or talking, stops playing and cannot start activity again, or lips or fingernails turn gray or blue.

EMERGENCY PLAN

- Give rescue medication (bronchodilator) and repeat _____ times _____ minutes apart.
- If there is no or little improvement within 15 minutes after the first treatment call 911.

Physician's Signature _____
Date

I agree with the recommendations of my child's physician as noted above.

Parent/Guardian's Signature _____
Date