Lubbock ISD
Every Child Every Day

Parent/Physician Authorized School Asthma Management Plan

Student: _____ **Date of Birth:** _____

Allergies: _____ **Teacher:** _____ **Grade/Room:** _____

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Asthma Triggers: (Check each that applies to the student)

_____Exercise	_____Animals	_____Emotions/stress	_____Pollens
_____Respiratory infections	_____Smoke, odors or fumes	_____Change in temperature	_____Molds
_____Carpets in room	_____Food _____	_____Other _____	_____Chalk dust

Student's Daily Medications: (Please list all medications administered at home and at school-include nebulizer treatments)

_____ _____ _____

_____ _____ _____

I request that this School Asthma Management Plan be implemented for my child according to the signed protocol below from my child's physician. I hereby give my permission for the school nurse to consult with the prescribing physician regarding these orders.

Parent/Guardian Signature _____ Date: _____

Emergency Phone Numbers: _____

TO BE COMPLETED BY PHYSICIAN:

EMERGENCY ACTION is necessary when this student has symptoms such as:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

STEPS to take during an asthma episode:

1. Give Emergency Asthma Medications: (Parents must provide medications to school)

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: _____

PHYSICIAN AUTHORIZATION FOR ASTHMA SELF-CARE:

☐ I have instructed this student in the procedure to use his/her asthma medication and it is my professional opinion that this student **SHOULD** be allowed to carry and self-administer the medication while on school property or at school-related events. This student has my permission to self-administer the medication as directed above, on a properly labeled container, at the times and dosages indicated above.

☐ It is my professional opinion that this student **SHOULD NOT** carry and self-administer his/her asthma medications while on school property or at school related events.

Printed Name of Physician: _____ Date: _____

Physician's Signature: _____

Physician's Office Number: _____ FAX: _____