Carroll ISD Health Services
Parental Authorization for Asthma Action Plan 2020-2021

Parent please answer:
Special Ed services? yes / no
Active 504 plan? yes / no
I would like 504 information yes / no

Name:_______________________________________ D.O.B.:____________ Grade/Teacher:____________________
Parent/Guardian: _____________________________________ Phone: ____________________________
Parent/Guardian: _____________________________________ Phone: ____________________________
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # __________
Before/After school activities: ☐ Athletics ☐ Band ☐ Club: _______________ ☐ Tutoring ☐ Other_____________

Asthma History

At what age was student diagnosed with asthma/reactive airway disease? __________
Has student had an asthma attack in the last 3 months that required an Emergency room visit? ☐ NO ☐ YES
Asthma Triggers: *(check all that apply)*

___ Viral Infection (cold, flu, sinus, bronchitis)
___ Exercise/sports
___ Hot or cold temperatures
___ Stress, anxiety, strong emotions
___ Seasonal allergies/pollen: _________________________________
___ Other allergens (dust mites, animal dander/fur, feathers)
___ Environmental irritants (smoke, perfume, aerosols, dust, paint, odors)
___ Other: ____

Asthma Symptoms: *(check all that apply)*

___ Shortness of breath
___ Coughing
___ Wheezing
___ Tightness in chest
___ Pale face/lips
___ Rapid, shallow breathing
___ Anxious, fearful, strong emotions
___ Retraction of chest muscles
___ Other: ____

List any preventative medication taken at home on a regular basis:
____
____

List any emergency or "as needed" medication taken at home *(inhaler or nebulizer for example)*:
____
____

Does student require Peak flow monitoring? ☐ NO ☐ YES Personal Best Number: ______________

Management of an Acute Asthma Episode in School

If student has wheezing, shortness of breath, chest tightness, excessive coughing, rapid breathing or exaggerated intake of air in an effort to fill lungs:

- Stop activity and get student into a comfortable position.
- Speak calmly and reassuringly to student. Encourage slow deep breathing.
- Escort student to clinic or call nurse immediately for onsite assistance. Never leave student alone.
- If available, administer prescribed medication by inhaler or nebulizer. If student carries an inhaler, assist with administering inhaler as soon as possible. Student should respond to treatment within 15-20 min.
- If medication is ineffective and/or student show signs of distress, call 911 to activate emergency services. Signs of distress include:
    - Labored breathing with flaring of nostrils, gasping or grunting when breathing in
    - Breathing becomes hard and fast and student is hunched over or ribs are visible when trying to take a breath
    - Student appears exhausted, pale, or lips/fingertips begin to turn blue
    - Student can no longer talk or becomes unconscious or stops breathing.
- Notify parent or guardian

Other ____

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Medication at School

Will student have rescue medication at school? ☐ NO ☐ YES*

If yes, check all that apply: ___ Inhaler ___ Nebulizer ___ Epinephrine

* *A medication administration form is required for all prescription medications. This form can be found on the Carroll ISD website under the Department of Health Serves, Medication & Health Forms.*

Does student need to pre-medicate before PE/athletics/recess? ☐ NO ☐ YES, always ☐ YES, as needed

For intermediate through high school students, will student self-carry and self-administer his/her inhaler?

☐ NO ☐ YES If yes, complete Self-Administered Inhaler section below.

Parent Instructions for Self-Carry and to Self-Administer Inhaler at School

For parents of students in grades 5-12, please initial one of the following statements:

__________ My child, ______________________________, has been instructed in the proper way to use his/her inhaled medication. (See Student Contract below.) My student should be allowed to carry & use his/her own inhaled medication. **It is advisable to keep a second inhaler in the nurse's office.*

__________ It is my opinion that my student should not be allowed to carry or use his/her own inhaled medication. Please assist my student with medication if signs or symptoms of respiratory difficulty present.

Intermediate through High School Student Contract for Self-Carry & to Self-Administer Inhaler at School

By initialing each statement & signing below, the student indicates their understanding and agreement with the following statements:

__________ I know how and when to use my inhaler and have discussed this with my doctor.

__________ I know it is my responsibility to keep my inhaler with me where it is easily accessible in case I need it during school hours, extracurricular activities, and field trips.

__________ I will notify the school nurse or a responsible school adult if I have used my inhaler and it is not working for me or if my symptoms return before I am supposed to use my inhaler again.

__________ I will notify the school nurse or my parents if my inhaler is lost, stolen or expired.

__________ I will not share my inhaler with anyone else.

__________ I understand that a "back up" inhaler in the nurse's office is advisable.

____

Student Signature **Date**

Parental Authorization

I grant permission to Carroll ISD to follow the above Action Plan for my child and to take whatever measure in their judgement may be necessary to provide emergency medical services consistent with this Action Plan, including the administration of medication to my child. I give permission to Carroll ISD to contact my physician for additional information as necessary. I grant the school nurse permission to share this Action Plan with my student's teacher(s). I also authorize Carroll ISD staff members to share the contents of my child's Action Plan with chaperones and other volunteers at school events or field trips as necessary to ensure the safety and well-being of my child.

____

Parent/Guardian Signature **Date**

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