CCS Asthma and Allergy Action Plan

Dear Parent/Guardian:
Allergies and asthma can cause severe medical emergencies. To allow students to use emergency asthma and allergy medicines, this form must be completed. Please ask your child's doctor to complete the form below then fax the completed document to CCS as soon as possible. FAX # 936-890-5343.

Student's Name _____ Date of Birth _____Grade _____

Parent/Guardian Name _____ Daytime Phone Number _____

Physician's Name _____ Phone Number _____

I. Please list any medications taken daily to manage asthma, including nebulizer treatments.

	Name of Medication	Dosage	Reason to Administer
1.	_____	_____	_____
2.	_____	_____	_____

Physician:

II. Please list any medical equipment this student will need to treat his/her asthma or severe allergies while at school (i.e. medication, inhaler, nebulizer, or EpiPen).
_____

III. Use of personal Inhaler or Bronchodilator: The student **must** have permission from their physician to carry and self-administer inhalers on school campus.

__ I have instructed this student in the proper way to use his/her medications. It is my professional opinion that this student should be allowed to carry and self-administer the following medications while on school property or at school-related events.
_____

Or **__ It is my opinion that this student should <u>not</u> be allowed to carry and self-administer the following medications while on school property or at school-related events.**
_____

IV. Steps to take during an Asthma episode:

1. Give emergency medications – Name: _____
   Dosage _____ Reason to Administer: _____
   Repeat for severe breathing difficulty _____times _____ minutes apart.

2. **Seek emergency medical care if this student experiences any of the following:**
   No improvement within 15-20 minutes after initial treatment with medication and a relative cannot be reached**. If student exhibits**: Chest and neck pulled in with breathing, hunched over while breathing, struggling to breathe, trouble walking or talking, stops playing and cannot start activity again, lips or fingernails turn gray or blue. **Call 911 or EMS if minimal or no improvement.**

   Comments or special instructions: _____

Physician Signature _____ Date _____

Parent:

I give permission to my child's school to administer daily and emergency medications as necessary in accordance with the physician's instructions above.

Parent/Guardian Signature _____ Date _____