Belton ISD Health Services
Parent Authorization for Asthma Emergency Plan
School Year: 2019-2020 Campus:

Student Last Name	**Student First Name**	DOB	Grade/Homeroom	Transportation: ○ Rides bus #_____ ◉ Car rider ○ Walker

○ No ○ Yes Student in Special Education Program? ○ No ◉ Yes Student in 504 Program? (School accommodations for those with chronic health conditions)

Age asthma diagnosed: _____
○ No ◉ Yes Student permitted to carry & self-administer their inhaler
○ No ◉ Yes Student has had an asthma attack in the last 3 months that required an emergency room visit
○ No ◉ Yes Student has known triggers that should be avoided. If yes, list:
_____
○ No ◉ Yes Student understands when to limit physical activity
○ No ◉ Yes Student knows when & how to tell an adult they may be having an asthma attack

List asthma prevention medications taken at home:

***Asthma rescue inhaler**: Medicine/Route/Dosage/Times	Pharmacy/RX #	Expiration Date

Specific medication instructions/ precautions/ side effects on your child:

Medication will be kept at school:
☐ N/A ☐ In health office ☐ Student will carry backpack ☐ Other: _____

Standard Asthma Emergency Plan for School

<u>To physician</u>: Please review standard asthma emergency plan for school and fill in the spaces concerning repeating inhaler when student in the RED ZONE. Add additional instructions as needed.

If you see this:	Do this:
Yellow Zone: Getting Worse	
▪ **Student complains of shortness of breath** ▪ **Wheezing** ▪ **Persistent coughing** ▪ **Tightness in the chest** ▪ **_____**	▪ **Stop activity** ▪ **Student Needs their *asthma rescue inhaler** **_____** **Medicine/Route/Dosage/Times** ▪ **Call the nurse/ office for assistance** ▪ **Sit student up in comfortable position** ▪ **Stay with student- DO NOT LEAVE ALONE**
Red Zone: Danger	
▪ **Medicine is not helping** ▪ **Breathing is hard and fast** ▪ **Nose opens wide** ▪ **Can't walk** ▪ **Ribs show** ▪ **Can't talk well**	▪ **Continue to assist student with their asthma medication** ▪ **May repeat inhaler _____puffs, every ___minutes up to ___times in an hour while getting help** ▪ **Call or have someone CALL 911/ Mr. MERT (call nurse/principal/parent)** ▪ **Start CPR if indicated** ▪ **Additional instructions:**

Physician: Print Name	**Physician Signature**	**Physician Phone**	**Date**

I grant permission to Belton ISD to administer this medication to my child. I am giving permission to BISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may give the medication.

Parental Signature	**Best emergency phone**	**Other phone**	**Date**
Emergency Contact	**Phone**	**Other phone**	

Trained Staff-Print name and initial after completing training on administering this medication, which includes seeking additional training or assistance as needed when administering this medication. **Trainer-** sign and date beside name of staff member that has completed the knowledge and skills to administer this medication.

Trained staff: Print Name/initial	**Trainer Signature**	**Training Date**	**Trained staff: Print Name/initial**	**Trainer Signature**	**Training Date**

If administered:	**Date**	**Time**	**Initials**	**Date**	**Time**	**Initials**

Reviewed 5/19/cs

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THE FOLLOWING IS TO BE COMPLETED BY THE SCHOOL NURSE for students who have received written authorization by the physician and parent <u>to carry and self-administer</u> their rescue inhaler:

Yes	**No**	
☐	☐	Demonstrated correct use/administration of asthma inhaler.
☐	☐	Recognizes proper and prescribed timing for medication
☐	☐	Agrees not to share medication with others
☐	☐	Agrees to keep medication in: _____ (location)
☐	☐	Agrees to come directly to the Nurse's Office if asthma symptoms persist

☐ **The student <u>has demonstrated</u> the purpose, appropriate method and frequency of his/her meter dose inhaler. I feel he/she shows sufficient responsibility to carry the inhaler on his/her person in school.**

Nurse Signature	Date