

Belton ISD Health Services
Parent Authorization for Asthma Emergency Plan

School Year: _____ Campus: _____

Student Last Name	Student First Name	DOB	Grade/Homeroom	Transportation: <input type="checkbox"/> Rides bus # _____ <input type="checkbox"/> Car rider <input type="checkbox"/> Walker
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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
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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

To physician: 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			
<ul style="list-style-type: none"> ▪ Student complains of shortness of breath ▪ Wheezing ▪ Persistent coughing ▪ Tightness in the chest ▪ _____ 	<ul style="list-style-type: none"> ▪ Stop activity ▪ Student Needs their *asthma rescue inhaler <p style="text-align: center;">_____</p> <p style="text-align: center;">Medicine/Route/Dosage/Times</p> <ul style="list-style-type: none"> ▪ Call the nurse/ office for assistance ▪ Sit student up in comfortable position ▪ Stay with student- DO NOT LEAVE ALONE 		
Red Zone: Danger			
<ul style="list-style-type: none"> ▪ Medicine is not helping ▪ Breathing is hard and fast ▪ Nose opens wide ▪ Can't walk ▪ Ribs show ▪ Can't talk well 	<ul style="list-style-type: none"> ▪ Continue to assist student with their asthma medication ▪ May repeat inhaler _____ puffs, every _____ minutes up to _____ times in an hour while getting help (can only be filled by PCP or per written orders) ▪ Call or have someone CALL 911/ Mr. MERT (call nurse/principal/parent) ▪ Start CPR if indicated ▪ Additional instructions: 		
<p>I grant permission to Belton ISD to administer this medication to my child. I understand that a trained unlicensed designee of the principal may give the medication. I am giving permission to the BISD school nurse to contact my physician for additional information if necessary and to notify my child's teacher(s) of his/her health condition.</p>			
Parent signature	Best emergency phone	Other phone	Date
Physician: Print Name	Physician Signature	Physician Phone	Date

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

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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 to carry and self-administer their rescue inhaler:

- | Yes | No |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Demonstrated correct use/administration of asthma inhaler. |
| <input type="checkbox"/> | <input type="checkbox"/> Recognizes proper and prescribed timing for medication |
| <input type="checkbox"/> | <input type="checkbox"/> Agrees not to share medication with others |
| <input type="checkbox"/> | <input type="checkbox"/> Agrees to keep medication in: _____ (location) |
| <input type="checkbox"/> | <input type="checkbox"/> Agrees to come directly to the Nurse's Office if asthma symptoms persist |

The student has demonstrated 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
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