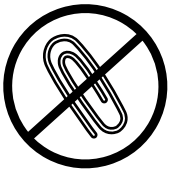
ASTHMA ACTION PLAN AND MEDICATION PERMISSION FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.

DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

EMAIL		MAIL
admissions@imanischool.org	-OR-	The Imani School Attn: Student Medical Records 12401 S. Post Oak Rd Houston, TX 77045

Asthma Action Plan

General Information:

■ Name _____

■ Student can self carry and self administer medication Yes No

■ Physician/healthcare provider _____ Phone numbers _____

■ Physician signature _____ Date _____

Severity Classification

○ Intermittent ○ Moderate Persistent
○ Mild Persistent ○ Severe Persistent

Triggers

○ Colds ○ Smoke ○ Weather
○ Exercise ○ Dust ○ Air Pollution
○ Animals ○ Food
○ Other _____

Exercise

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

○ Take quick-relief medication every 4 hours for 1 to 2 days.
○ Change your long-term control medicine by _____
○ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

○ Take quick-relief treatment again.
○ Change your long-term control medicine by _____
○ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

○ Still in the red zone after 15 minutes.
○ You have not been able to reach your physician/healthcare provider for help.
○ _____

Call an ambulance immediately if the following danger signs are present:

○ Trouble walking/talking due to shortness of breath.
○ Lips or fingernails are blue.

Form created by the American Lung Association

School Asthma Action Plan

(PHYSICIAN AUTHORIZATION FOR SELF-CARRY AND SELF-ADMINISTRATION OF ASTHMA MEDICATIONS)

This plan is in accordance with legislation, HB1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from physicians and parents. (To be completed each school year and kept on file with the school nurse or office of the principal.)

Bronchodilator (Quick-relief Medication)

Medication Name: _____

Purpose: _____

Dosage: _____

When to use: *SEE THE ATTACHED ASTHMA ACTION PLAN*

Additional Instructions: _____

I have instructed _____ in the proper way to use his/her medications.

It is my professional opinion that _____

☐ **SHOULD BE ALLOWED** ☐ **SHOULD NOT BE ALLOWED**

to carry and self-administer asthma medications while on school property or at school-related events:

Physician's Signature Date

I agree with the recommendations of my child's physician as noted above and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events.

Parent/Guardian Authorization Signature Date

The Imani School
Medication Permission Form
Parental Consent to Administer Medication During the School Day

Exp: #1 _____ #2 _____

Student's name | Date of birth | Weight (lbs.) | Medication allergies

I, _____, request and give permission for school personnel at The Imani School to give my child
Print parent/guardian name

(named above) the following medication(s) according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Medication #1 Expiration date:

Medication name:

Type of medication: ☐ Prescription ☐ Over the counter

Prescribed Dose: _____

Medication Strength: _____

Time(s) to be given: ☐ At: _____ ☐ Every _____ hours

☐ As needed

Initial Quantity: _____

Dates to be given: From _____ to _____

Reason for medication: _____

Medication #2 Expiration date:

Medication name:

Type of medication: ☐ Prescription ☐ Over the counter

Prescribed Dose: _____

Medication Strength: _____

Time(s) to be given: ☐ At: _____ ☐ Every _____ hours

☐ As needed

Initial Quantity: _____

Dates to be given: From _____ to _____

Reason for medication: _____

Parents, please review The Imani School medication policy in the Handbook before signing below.

Key Points:

- Medication must be provided by the student's parent/guardian. Over-the-counter medications are not supplied by the clinic.
- Medication must be in its original container with dosing instructions (not a blister pack, zipper-lock bag, or dosing syringe).
- Prescription medication must have a pharmacy label stating the child's name, the drug, the dose, and instructions.
- A parent's permission expires after 2 weeks. A physician must authorize medication that is kept in the clinic longer than 2 weeks.
- Expired medication cannot be administered. Unclaimed medication will be destroyed after the last day of school.
- Students are not allowed to self-carry medication on school property unless entitled by law (TEC Section 38.015).

→ **Parent/guardian signature:** _____ **Date:** _____

PHYSICIAN AUTHORIZATION

PHYSICIAN'S ORDERS FOR MEDICATION – REQUIRED FOR MEDICATION TO BE GIVEN OR KEPT IN THE CLINIC LONGER THAN 2 WEEKS

Please give _____ the following medications as directed:
Print student's name

Date prescribed	Medication	Dosage	Instructions

Physician's signature | **Date** | **Physician's name and phone number (stamp or print)**