



CONROE

INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

School Asthma Action Plan

Student Information

_____ Student's name

_____ Grade _____ School year _____ Date of birth

_____ Teacher's name

_____ Parent's/Guardian's name

_____ Parent's/Guardian's address

_____ Parent's/Guardian's home phone

_____ Parent's/Guardian's work phone

_____ Emergency contact name

_____ Emergency contact relationship

_____ Emergency contact phone number

_____ Physician student sees for asthma

_____ Physician's phone number

_____ Other physician

_____ Other physician phone number

Self-Administration of Asthma Medications

Bronchodilator (quick-relief medication)

_____ Name of medication

_____ Purpose of medication

_____ Dosage of medication

_____ When to use medication

Can be repeated for severe breathing difficulty
_____ times _____ minutes apart.
Call 911 or EMS if minimal or no improvement.

Other medication

_____ Name of medication

_____ Purpose of medication

_____ Dosage of medication

_____ When to use medication

_____ Additional instructions

- I have instructed (*student's name*) _____ in the proper way to use his/her medications. It is my professional opinion that (*student's name*) _____ **should be allowed** to carry and self-administer the following medications while on school property or at school-related events.
- It is my professional opinion that (*student's name*) _____ **should not be allowed** to carry and self-administer the following medications while on school property or at school-related events.

Physician's signature _____ *Date*

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

Parent's signature

Date