

School Photo

Gregory Portland Independent School District  
Health Services Department

**SCHOOL ASTHMA ACTION PLAN**

(Please Print)

Effective Date:

This plan is in accordance with the legislation, HB 1688, which passed in 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from parents and physicians. The information below should assist you if asthma symptoms or needs occur during school hours or school functions.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ First Phone: \_\_\_\_\_ Second Phone: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**SCHOOL ASTHMA ACTION PLAN:**

Please list any medications to be taken at school to manage ASTHMA

**GREEN ZONE: GO! ALL CLEAR.**

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

SPACER USE RECOMMENDED

Daily (GREEN ZONE) preventative Medication & Dose:

USE THIS MEDICATION 20 MINUTES BEFORE EXERCISE

**YELLOW ZONE: CAUTION**

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

SPACER USE RECOMMENDED

Quick Reliever Medication & Dose:

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once.

If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour, follow RED ZONE instructions.

**RED ZONE: STOP! MEDICAL ALERT!**

- Very short of breath or,
- Quick relief medication has not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in YELLOW ZONE

SPACER USE RECOMMENDED

The RED ZONE means start taking your RED ZONE medications and CALL YOUR DOCTOR NOW!!

If your symptoms do not get better and you can't reach your doctor, GO TO THE EMERGENCY ROOM OR CALL 911 IMMEDIATELY.

Continue Quick Relief as follows:

**SELF-ADMINISTRATION OF ASTHMA MEDICATION:**

**SELF - ADMINISTERED EMERGENCY MEDICATION**

(To be completed by a Physician)

I have instructed student, \_\_\_\_\_, in the proper way to use his/her medication. It is my professional opinion that this student **SHOULD** be allowed to carry and self-administer his/her medication.

\* A second inhaler in the nurse's office is advisable and recommended.

It is my professional opinion that this student **SHOULD NOT** carry or self-administer his/her medication.

The school will act based on the information provided here. It is expected that this form is accurate, complete, up-to-date and any changes will be communicated to the school in an expedited manner. BOTH parent AND medical provider signatures are required.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree with the recommendations of my child's physician as noted above, and I have informed my child of his/her ability TO carry or NOT to carry their asthma medications while on school property or at school related events and activities. I also understand that I will provide all medications and equipment needed for my child's treatment.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(revised 2/2020)