Williamson County Schools
Asthma Action Plan for School

(This form must be signed by the Physician)

Student Name _____ Date of Birth _____

School _____ Grade_____ School Year _____

ASTHMA RISK: ☐ Mild ☐ Moderate ☐ Severe

Triggers (list): _____

Control Medications Taken at Home _____

EMERGENCY ACTION PLAN

1. Contact School Nurse at _____.
2. Encourage student to remain calm, take slow, deep breaths, and sit upright.
3. Administer emergency medications below.
4. Stay with student and monitor. Nurse will utilize pulse oximeter as needed.
5. CALL 911 If symptoms persist after 15 minutes or if in doubt.
6. Notify parent or emergency contact.

Call 911 immediately if:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Medicine is not helping after 15 minutes
- No medication available and unable to reach parent

PHYSICIAN'S ORDER – EMERGENCY MEDICATIONS

Name of Medication	Strength and Dose to be Given	When to Administer at School

Special Instructions: _____

For Inhaled Medications (Please check ONE of the following):

☐ I have instructed this student in the proper way to use his/her inhaled medication. It is my professional opinion that he/she should be ALLOWED TO CARRY and use their prescribed inhaler.

☐ It is my professional opinion that this student SHOULD NOT carry his/her inhaled medications but should receive assistance with administration by an adult.

Physician's Signature _____ **Date**_____

Physician's Name (Print) _____ **Phone** _____

PARENT/GUARDIAN'S AUTHORIZATION (Required)

I give permission for the medication(s) listed to be administered in school by the nurse or other trained personnel. I consent to communication between the school nurse and prescribing health care provider or clinic to discuss asthma management and administration of the medication. The undersigned parent/guardian hereby agrees to exempt and release the school district and its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands, or actions whatsoever arising out of any damage, loss, or injury that my student or I/we might sustain or which they now have or may hereafter have arising out of the administration of this medication.

Parent/Guardian's Signature _____ **Date**_____

Parent/Guardian's Name (Print) _____ **Phone** _____

Medication received by _____ *Date* _____ *Exp. Date*_____