HARMONY SCIENCE ACADEMY
2031 S. Texas Ave, Bryan, TX 77802 ◆Tel: 979.779.2100 ◆Fax: 979.779.2110 ◆www.hsabcs.org

HARMONY SCIENCE ACADEMY-BRYAN/COLLEGE STATION SCHOOL ASTHMA TREATMENT PLAN

This plan is in accordance with the new legislative, HB 1688, 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 parents and physicians.

(To be completed at the beginning of each school year and/or when changes occur in treatment plan. To be kept on file with the school nurse.)

Student's Name: _____ Grade: _____ DOB: _____

Address: _____ School Year: _____

Parent/Guardian:

Mother: _____ 1st # to call: _____ 2nd # to call: _____

Address: _____

Father: _____ 1st# to call: _____ 2nd# to call: _____

Address: _____

Emergency Contact other than Parent:

Name: _____Relationship_____

1st # to call: _____ 2nd# to call: _____

Treating Physician for Asthma: _____ Phone Number: _____

Other Physician: _____ Phone Number: _____

□ 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:

A. Bronchodilator (Quick Relief Medication):

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Can be repeated for severe breathing difficulty _____times _____ minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other Medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional Instructions: _____

These medications are prescribed for the time period _____ until _____

□ It is my professional opinion that _____ (student's name) should **NOT** be allowed to carry and self-administer any of his/her 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 may child that he/she may/may not carry his/her asthma medications while on school property or at school-related events.

Parent/Guardian's signature: _____Date:_____

Date received at school: _____ Nurse Signature: _____

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HARMONY SCIENCE ACADEMY-BRYAN/COLLEGE STATION EMERGENCY ASTHMA TREATMENT PLAN

Emergency action is necessary when this student has symptoms such as:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Steps to take during an asthma episode:

1. Give Emergency Mediations:
   A. Bronchodilator(Quick-relief Medications):
      Name: _____
      Purpose: _____
      Dosage: _____
      When to use: _____
      Can be repeated for severe breathing difficulty _____times _____ minutes apart.
      CALL 911 OR EMS IF MINIMAL OR NO IMPROVEMENT
   B. Other Medications:
      Name: _____
      Purpose: _____
      Dosage: _____
      When to use: _____
      Additional Instructions: _____

These medications are prescribed for the time period _____ until _____

2. **Seek emergency medical care if this student experiences any of the following:**
   - **No** improvement 15-20 minutes after initial treatment with medication and a relative can not be reached.
   - **Student** exhibits any of the following:
   - ♦ Chest and neck pulled in with breathing ♦ Struggling to breathe ♦ Trouble walking or talking
   - ♦ Stops playing and cannot restart activity ♦ Hunched over while breathing ♦ Lips or fingertips gray or blue

Comments and special instructions:

_____

_____

_____

Physician's Signature: _____Date: _____

I give permission for my child's school to administer daily and emergency medications as necessary, in accordance with the Physician's instructions above. I also understand that I am required to supply the school with all medications and if the student is able to carry own inhaler, will provide nurse emergency medications to keep locked in nurse's area. If I am unreachable I understand the school may send my child to the nearest hospital via EMS.

Parents Signature: _____Date:_____

Nurse Signature: _____Date: _____ Medications received to office? _____

Expiration Date: _____