



**CONROE**

INDEPENDENT SCHOOL DISTRICT

*Committed to Excellence*

# Asthma Daily Treatment Plan

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**Please list any medications taken daily to manage asthma, including nebulizer treatments.**

Name of medication	Purpose	Dosage	When to use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

These medications are prescribed for the time period from \_\_\_\_\_ until \_\_\_\_\_

**Medical Equipment.**

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Steps to take during an asthma episode.**

**1. Give emergency medications**

**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.

**Other medications**

Name \_\_\_\_\_ Purpose \_\_\_\_\_

Dosage \_\_\_\_\_ When to use \_\_\_\_\_

Additional instructions

**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 cannot be reached.
- Student exhibits:

*Chest and neck pulled in with breathing  
Hunched over while breathing*

*Struggling to breathe  
Trouble walking or talking*

*Stops playing and cannot start activity again  
Lips or fingernails turn gray or blue*

Comments or special instructions \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

**I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with the physician's instructions above.**

\_\_\_\_\_  
Parent's/Guardian's signature

\_\_\_\_\_  
Date