Bryan ISD Nursing Services

Asthma/Respiratory Distress Action Plan

Student Name:_____ **DOB:** _____ **ID Number:** _____

Parent/Guardian (*Padre/Tutor)*_____ Phone (*Teléfono)* _____

Emergency Contact (Contacto de Emergencia) _____ Phone (*Teléfono)* _____

Parent/Guardian Consent to Administer Medications/Autorización de los padres/tutores para la administración de medicamentos

I, the parent/guardian of the named student, request that this action plan be used to guide care for my child and consent to the administration of medications as prescribed by the physician. I agree to: (*Yo, el padre/tutor del estudiante nombrado, pido que este plan de acción sea utilizado para guiar el cuidado de mi hijo y doy mi autorización para la administración de medicamentos según lo recetado por el médico. Estoy de acuerdo con:)*

1. Provide necessary supplies, equipment, and medications. *(Proporcionar los materiales, el equipo y los medicamentos necesarios.)*
2. Notify the school nurse of any changes in the student 's health status and complete a new consent form if any changes in the orders are made from the physician. (*Informaré a la enfermera de la escuela de cualquier cambio en el estado de salud del estudiante y completaré un nuevo formulario de consentimiento si hay cambios en las órdenes del médico.)*
3. Authorize the school nurse to communicate verbally and in writing with the student 's health care provider about this condition and corresponding orders/action plans. *(Autorizar a la enfermera de la escuela para que se comunique verbalmente y por escrito con el proveedor de atención médica del estudiante sobre esta condición y las órdenes o planes de acción correspondientes.)*
4. School staff interacting directly with my child may be informed about his/her condition and corresponding medical needs while at school. *(El personal de la escuela que interactúa directamente con mi hijo puede ser informado sobre su condición y sus necesidades médicas correspondientes mientras está en la escuela.)*

_____ _____

Parent/Guardian Signature *(Firma del Padre/Tutor)* **Date *(Fecha)***

To Be Completed by Physician

Diagnosis: _____

Symptoms Student May Exhibit (Please check all that apply)

☐ Severe Cough	☐ Blueness of Fingernails/Lips	☐ Retractions (sucking in of chest wall)
☐ Chest Tightness	☐ Rapid/Labored Breathing	☐ Difficulty Walking
☐ Wheezing	☐ Rapid/Shallow Breathing	☐ Difficulty Talking
☐ Shortness of Breath	☐ Decreased or Loss of Consciousness	☐ Other: _____

Physical Activity Restrictions:

Call 911 If:

Medication *(provided by parent/guardian)*	**Dose**	**Instructions**

Oxygen Administration Orders	**L/Min, Mode of Administration**	**Instructions**
☐ **Yes** ☐ **No** ☐ **N/A**		

Pulse Oximetry Orders	**Oximetry Parameters**	**Corresponding Interventions**
☐ **Yes** ☐ **No** ☐ **N/A**	**SpO2 > 95%**	
	SpO2 = 90% -95%	
	SpO2 = 85%-90%	
	SpO2 < 85%	

For Inhaled Medications:

☐ It is my professional opinion that this student **<u>should</u>** carry his/her inhaled medication. He/she has been instructed in the proper use of this medication/inhaler.

☐ It is my professional opinion that this student **<u>should not</u>** carry his/her inhaled medication.

Physician Name (printed): _____ Phone number: _____

Physician Signature: _____ Date: _____

This plan is valid for current school year including summer school unless changes are made