Asthma Daily Treatment Plan

CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

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 *Struggling to breathe* *Stops playing and cannot start activity again*
Hunched over while breathing *Trouble walking or talking* *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*