Asthma Medical Care Plan

Care plan is valid for one calendar school year and must be updated by a physician with any changes made to medication dose or frequency throughout the school year.

Student's Name: ____ School Year: ___________________

Date of Birth: _____________________ School/Program: ____

Age: ____________ Grade: _______________ Teacher: ____

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician/ licensed prescriber.
Without **both** signatures this care plan is not valid. Parent/guardian is responsible for supplying all medication & any other supplies required for administration.

Contact Information

First Contact	**Second Contact**
Name: ______________________________________	Name: ______________________________________
Relationship: ________________________________	Relationship: ________________________________
Phone (1): __________________________________	Phone (1): __________________________________
Phone (2): __________________________________	Phone (2): __________________________________

Third Contact (If a parent/guardian cannot be reached, must be listed on emergency card)

Name: ________________________________Phone: ____________________ Relationship: _____________

Asthma History

Asthma Triggers - may cause an asthma episode at school (please circle all that apply)

Exercise	Animal dander	Cold weather/extreme temperatures
Dust/carpet	Grass/pollen	Respiratory Illness (colds)
Insect sting	Strong odors	Other:______________________

For asthma my child has/uses the following:

☐ YES ☐ NO A spacer (please provide spacer, if required for use at school) Helps improve medication delivery
☐ YES ☐ NO Medication at home (other than rescue) to control asthma
☐ YES ☐ NO A nebulizer (breathing machine) at home
☐ YES ☐ NO I will supply the school with a backup inhaler if my child is to self carry (form must be filled out)
☐ YES ☐ NO I have read the attached information regarding Section 504 eligibility
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation
☐ YES ☐ NO Will a peak flow be used? If so, please provide student's personal best:___________

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having asthma to better identify needs. I give permission for trained staff to administer the medication ordered for asthma on page 2 of this plan and to contact the ordering physician or licensed prescriber for clarification of orders, if needed.

____ ____________________
Parent Signature **Date**

Holly Area Schools do not have medical personnel present to administer medication / treatment.
If appropriate, please order medication / treatment to be administered at home.

Holly Area Schools - Asthma Medical Care Plan

Student Name: ______________________________ **Date of Birth:** _____________ **School Year:** ____________

Signs of Asthma Attack

- Wheezing (noisy breathing)
- Peak flow reading below 80% of personal best
- Shortness of breath
- Difficulty breathing
- Coughing or repeated clearing of throat
- Complains of chest tightness or pressure

Action

- Remain calm
- Have the student sit up right and relax
- Encourage slow deep breathing:
  In through the nose and out through puckered lips
- Give medication as ordered (spacer if ordered)
- Stay with the student until breathing normally
- Notify parent if symptoms do not resolve

Signs of Asthma EMERGENCY- (No improvement 10-15 minutes after medication is given)

- Breathing difficulty gets worse
- Skin pulls in around collar bone or ribs with each breath (shoulders may rise)
- Looks anxious, frightened, restless, sitting hunched over
- Cannot talk in a complete sentence or walk and talk
- Stops playing and cannot start activity again
- Pale color or blue around mouth or nail beds (skin may be damp)

Action

- **First CALL 911**, then **Parent/Guardian** and then district nurse
- Repeat medication, if ordered, while waiting for emergency help to arrive
- Start **CPR**, if breathing stops

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Rescue Medication:
Metered dose inhaler (MDI) Medication:____________________________________ **Dose**____________
Frequency: ___________________________ **May repeat in** ______ **minutes if no help or symptoms worsen**
Route: Oral Inhaler   Side Effects________________________________

Daily Medication needed at school:
Metered dose inhaler (MDI) Medication:______________________________________ **Dose**____________
Frequency: ______________________ Route: Oral inhaler   Side Effects___________________________

Nebulizer (breathing machine) Medication:_____________________________________**Dose** __________
Frequency: ___________________________ Route: Oral NEB
Nebulizer instructions____

Peak Flow to be used at school: ☐ YES ☐ NO (peak flow must be provided by parent if ordered)

Personal Best: _________________ Yellow Zone: __________________ Red Zone: ____________________

☐ YES ☐ NO Medication is needed 20 minutes before PE/recess/strenuous exercise
☐ YES ☐ NO Student can use inhaler correctly, knows when to get adult help, not to share, and how to properly maintain the device. Therefore, it is my professional opinion, this student may be allowed to self-carry their inhaler.

Physician/Licensed Prescriber Name (Print): ____

Phone Number: __________________________________ **Fax Number:** _____________________________

Signature: ____ **Date:** _________________________