Holly Area Schools

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

Name: _____

Relationship: _____

Phone (1): _____

Second Contact

Name: _____

Relationship: _____

Phone (1): _____

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)
☐ 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 Will a peak flow be used at school? If so, please provide student's personal best:_____

I certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications at school. I agree to have the information in this two page plan shared with staff needing to know. I will not hold the HAS Board of Education, personnel, or its employees responsible for complications related to medication or treatment/care administered in pursuant to this plan. I give permission for trained staff to administer the medication ordered for asthma on page 2 of this plan and I give authorization for staff to contact the licensed prescriber for clarification of orders, if needed.

_____ _____

Parent Signature **Date**

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

5/2024 Office Use: Skyward Alert: ___ Email: ____ Date: _____ Initials: _____

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: _____ Indication for use: _____
Frequency: _____ **May repeat in _____ minutes if no help or symptoms worsen**
Route: Oral Inhaler Potential Side Effects:_____

Daily Medication (if needed at school) Metered dose inhaler (MDI):
Medication:_____ Dose: _____ Route: _____
Frequency: _____ Indication for use: _____
Potential side effects: _____

Nebulizer: Medication:_____ Dose: _____ Route: Oral NEB
Frequency: _____ Indication for use: _____
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:** _____