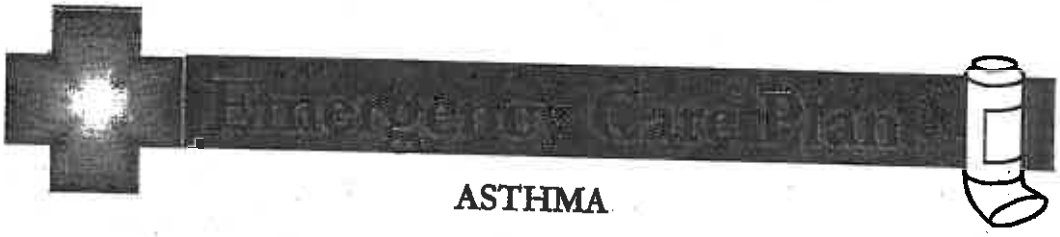

Sample

ASTHMA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthma Triggers: _____ Best Peak Flow: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow of < _____.
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED:

❑ Administration ❑ Classroom Teacher(s) ❑ Support Staff ❑ Special Area Teacher(s) ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication as ordered: _____
Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
Notify school nurse at _____ who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- Call 911 (Emergency Medical Services) and inform the that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
- A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Telephone _____

Address _____ Date of Birth _____

School _____ Room _____

1. I am requesting permission for my child named above to: (Check one or both)

   _____ use or receive medication

   _____ receive treatment

   in accordance with the Doctor's prescription.

2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.

3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent or Adult Student _____ Date _____

Home Telephone _____ Work Telephone _____

PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to _____
Student

_____ _____
Medication Dosage

Medication is to be taken at the following times _____

Instructions or precautions (including possible side effects): _____

_____

_____

_____
Treatment

Beginning Date _____ Expiration Date _____

Physician _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student:

_____

_____

_____

_____
Principal