HARVESTCHRISTIANACADEMY

ASTHMA CARE PLAN

STUDENT NAME: _____**D.O.B:** _____**Grade:**_____

Emergency Contact

1. Name: _____Relationship:_____ Phone: _____

2. Name: _____Relationship:_____ Phone: _____

3. Physician Name: _____ Phone: _____

EMERGENCY PLAN

Asthma Symptoms such as: _____

STEP 1- Give medications in order as listed below. Student should respond to treatment in 15-20 minutes.

Emergency Medication Name	Amount	When to Use
1.		
2.		
3.		

STEP 2- Contact parent/guardian if

_____

_____

STEP 3- Seek emergency medical care if the student has any of the following:

__ Coughs constantly
__ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
__ Hard time breathing along with:
. Chest and neck pulled in with breathing
. Stooped body posture
. Struggling or gasping
__ Trouble walking or talking
__ Stops playing and can't start activity again
__ Lips or fingernails are grey or blue

IF THIS HAPPENS, GET HELP NOW!

See side 2 for more instructions

DAILY ASTHMA MANAGEMENT PLAN

Home Medication

Name	Amount	When to Use
1._____		
2._____		
3._____		

Identify the things which start an asthma episode (Check each that applies to the student.)

___ Exercise ___ Strong odors or fumes ___ other

___ Respiratory infections ___ Chalk dust / dust ___ Animals

___ Change in temperature ___ Carpets in the room ___ Pollens

___ Food _____, _____, _____, _____ ___ Molds

Comments_____

Control of School Environment: (List any environmental control measures that the student needs to prevent an asthma episode: _____

Comments Special Instructions: _____

AUTHORIZATIONS

_____ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature: _____Date:_____

Parent/Guardian Authorization:

- I request this medication be administered as ordered by the student's licensed health care provider.
- I give Health Services staff permission to communicate with the health care provider about this medication.
- I understand that these medications may be administered by a certified staff member who has reviewed this care plan and the use of emergency medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. *Expired medication can not be administered!*
- Medication must be in the original prescription container with instructions as noted by above health care provider.

Parent/Guardian Signature: _____Date:_____