Muscogee County School District
Student Health Services
ASTHMA STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Asthma Healthcare Provider:		**Phone Number:**	

Emergency Plan

Emergency action is necessary when the student has symptoms such as _____

_____, _____ or has a peak flow reading of _____.

STEPS TO TAKE DURING AN ASTHMA EPISODE:

1. Check peak flow (if available).
2. Give emergency medications* below. Student should respond to treatment in 10-15 minutes.
3. Contact parent/guardian if: _____
4. Recheck peak flow.
5. **CALL 911** (Emergency Medical Services) if the student has any of the following:

   Please check all appropriate boxes

   - ☐ Coughs constantly
   - ☐ No improvement 15-20 minutes after initial treatment with medications
   - ☐ Hard time breathing with chest and neck pulled in with breathing, stooped body posture or gasping
   - ☐ Trouble walking and talking
   - ☐ Stops playing and can't start activity again
   - ☐ Lips or fingernails are grey or blue

2/2018
School Nurses Sharepoint Document Location: Forums > Care Plans

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Emergency Asthma Medications
Please provide the school with ALL appropriate emergency medications.

Medication Name	Dosage (amount)	When to use

Daily Asthma Management Plan
Check the triggers of an asthma episode for the student:

- ☐ Exercise
- ☐ Strong odors or fumes
- ☐ Food: _____
- ☐ Respiratory infections
- ☐ Chalk dust/dust
- ☐ Molds
- ☐ Change in temperature
- ☐ Carpets in the room
- ☐ Other: _____

Control of School Environment

1. Environmental control measures: _____
2. Pre-medications:_____
3. Dietary restrictions: _____

Peak Flow Monitoring

Student's Personal Best Peak Flow Number: _____ Monitoring times: _____

Daily Asthma Medications

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

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Comments and Special Instructions

_____

_____

_____

_____

Physician's Authorization for Inhaled Medications

- ☐ I have instructed the named student in the proper way to use his/her medication. It is my professional opinion this student should be allowed to carry and use that medication by him/herself.
- ☐ It is my professional opinion the named student should not carry and/or self-medicate with the above medication.

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders
- ☐ Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____Phone Number: _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian Consent for Management of Asthma at School

I _____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's asthma and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____**Date:** _____