School District of Manawa
"Students Choosing to Excel, Realizing Their Strengths"
800 Beech Street | Manawa, WI 54949 | (920) 596-2525
District Fax (920) 596-5308 | Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

ASTHMA MANAGAEMENT PLAN

School Year _____

Student _____ Birth Date ___/___/___ Age _____ Grade _____

School Attending:
☐ Elementary School • Phone (920) 596-5700 • Fax (920) 596-5339 Teacher/Advisor _____
☐ Little Wolf Middle/High School • Phone (920) 596-5800 • Fax (920) 596-2655 Teacher/Advisor _____

PARENT • GUARDIAN • EMERGENCY CONTACT

Parent / Guardian 1	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -
Parent / Guardian 2	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -
Emergency Contact 3	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -

INTERVENTION – If the student displays:

- Shortness of Breath
- Excessive Coughing
- Wheezing
- Chest Tightness
- Cannot Catch Breath
- Anxiety/Nervousness
- Peak flow of _____
- Other (specify) _____

Then:

1. Stop activity/remove student from aggravating factor.
2. Have student sit in upright position.
3. Check peak flow if possible.
4. Give emergency medications as listed in plan.
5. Stay with student and observe for worsening symptoms or symptoms are not improving
6. Notify parent/guardian or emergency contact.
7. Recheck peak flow if possible.
8. Other, specify _____

If the student fails to respond to medication to reduce symptoms and/or symptoms worsen after 10-15 minutes, follow directions for emergency response.

EMERGENCY RESPONSE – If the student displays

- Inability to speak in complete sentences without taking a breath
- Difficulty walking or talking
- A decrease in/or loss of consciousness
- Constant coughing
- Flaring nostrils
- Pulling in of neck/chest during breathing
- Blueish or grey lips or fingernails
- Sitting in a hunched over position (stooped body posture)
- A pulse oximeter reading of less than 90
- Has a peak flow of _____

Then:

1. CALL 911
2. Administer emergency medications as listed in plan if timing is appropriate (monitor for appropriate timing between doses/if medications can be repeated
3. Notify parent/guardian or emergency contact
4. Other, specify _____

EMERGENCY MEDICATIONS

Place in correct order to administer. Ensure amount of time between doses or if medication dosage cannot be repeated.

Order	Type/Name	Dosage	Frequency/Timing	Special Instructions/Negative Side Effects
1				
2				
3				
4	Other, specify			

DAILY/PREVENTATIVE ASTHMA PLAN

Identify triggers which can cause asthma symptoms: _____

If the student will require the use of an inhaler to prevent asthma symptoms, specify when and under what conditions it will be needed, i.e., before gym class, recess, etc.

DAILY INHALED MEDICATIONS

To be taken at school as a preventative measure.

Order	Type/Name	Dosage	Frequency/Timing	Special Instructions/Negative Side Effects
1				
2				
3				
4	Other, specify			

CONSENT FOR MANAGEMENT OF HEALTH CONDITION AT SCHOOL OR SCHOOL-SPONSORED ACTIVITIES

I, the parent/legal guardian, of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Further, I agree to:

1. Provide necessary supplies & equipment in original pharmacy labelled container and/or manufacturer's packaging and within the expiration date.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify school staff or school district nurse; complete new forms for any changes in the student's health status, orders from the student's health care provider, etc.
4. Ensure this form is signed by the appropriate medical provider who manages the medical condition, prescription and/or in doses that exceed the manufacturer's recommended dosages for non-prescription medications or over-the-counter (OTC) medications.
5. Authorize designated school staff or school nurse to communicate directly with primary care provider or specialist regarding health condition & medication.
6. Authorize school staff interacting directly with my child to be informed about this health care plan.
7. Submit new forms annually if the health condition and/or need for medication still exists or inform the school that the condition no longer exists and provide documentation of such, if deemed necessary.
8. Hold without liability the School District of Manawa, its' Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Legal Guardian Signature _____ Date _____

Student signature is required if student is 18 years old or attaining 18 years old during the school year

Student Signature _____

Date _____

PHYSICIAN INFORMATION/SIGNATURE

Print Name _____ Phone ( )

Medical Facility _____ Fax ( )

Address _____ City, State, Zip _____

For students in 5th grade and up

☐ I have instructed the student in the proper way to use his/her medications. It is my opinion that he/she should be allowed to carry and administer inhaled medication by him/herself.

☐ It is my opinion that the student should not carry nor administer his/her inhaled medication by him/herself.

Physician Signature _____ Date _____

PHYSICIAN: PLEASE ENSURE AN ASTHMA MANAGEMENT PLAN IS PROVIDED

School RN Signature _____ Date _____