School District of Manawa

Student Health Services

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Asthma Management Plan 2017/2018

Student Name _____ Date of Birth _____

School _____ Teacher _____

Student ID # _____ Grade _____

Home Street Address_____

City_____ State _____Zip Code_____

Parent/Guardian Name _____

Parent/Guardian Name _____

Please keep all parent/guardian and emergency contact information current with school office staff. In the event of an emergency we will attempt to contact parents/guardians followed by emergency contacts in the order on file.

Will your child take asthma medication at school (including nebulizer treatments)? ☐ YES ☐ NO

If your child will take asthma medication at school, please check one of the two following options:

1. ☐ This student may carry and self-administer medication for asthma-only 7th grade and older (still need to complete whole form).

If student may carry and self-administer asthma medications parent must complete the information in this box:

Release from Responsibility for Self-Administration of Medication:

I, _____, hereby give authority for _____, to carry and administer his/her
(Parent/Guardian Name) (Student Name)

own _____, during school hours.
(Name of Medication(s))

I release the school from any responsibility regarding medication errors incurred during school hours. I further understand that my child must carry the medication in its original container with the original prescription label containing the medication information and student's name affixed.

2. ☐ This student needs supervision and/or assistance with administration of asthma medication.

Write in your child's best peak flow _____

What triggers your child's asthma? ☐ Illness ☐ Exercise ☐ Allergies ☐ Cold Air ☐ Other (explain) _____

Describe your child's typical asthma symptoms: _____

Please list any other accommodations, considerations, or precautions that need to be made. _____

Will your child take asthma medications daily at school, regardless of symptoms? ☐ NO ☐ YES if yes, please fill in chart below.

DAILY Asthma Medications to be taken at school (please put in chart in correct order to administer).

Medication Name	Dose (amount)	Frequency/Timing (how often/when)	Nebulizer or Inhaler?	Special Instructions

Turn Over

Moderate symptoms of asthma:

- Shortness of breath
- Excessive coughing
- Wheezing
- Chest tightness
- Cannot catch breath
- Anxiety/nervousness
- Stands with shoulders hunched over
- Peak flow less than _____

SEVERE/EMERGENCY symptoms of asthma:

- Failure of medication to reduce symptoms/worsening symptoms after 15-20 minutes
- Grunting during breathing
- Inability to speak in complete sentences without taking a breath
- Sits hunched over
- Nasal flaring
- Neck/chest pull in during breathing
- Blueish or pale lips, skin, or nail beds
- Peak flow less than _____
- Pulse oximeter reading of less than 90%
- Decrease or loss of consciousness
- Difficulty walking or talking
- Respirations greater than 30/minutes
- Pulse greater than 120/minute

Instructions to follow if moderate asthma symptoms occur at school:

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. Put on pulse oximeter and check result if possible
6. Stay with student and observe for worsening symptoms
7. Notify parent/guardian or emergency contact
8. Other_____

If symptoms worsen or do not improve after 15-20 minutes, follow directions for severe/emergency asthma symptoms.

Instructions to follow for SEVERE/EMERGENCY asthma symptoms occur at school:

1. Call 911
2. Administer emergency medications as listed in plan if timing is appropriate (monitor for appropriate timing between doses/if meds can be repeated)
3. (Re)Check peak flow if possible
4. Place oximeter and check result if possible
5. Notify parent/guardian or emergency contact
6. Other_____

EMERGENCY Asthma Medications to be taken at school (please put in chart in correct order to administer, be sure to specify the amount of time between doses or if the medication should only be given once).

Medication Name	Dose (amount)	Frequency/Timing (how often/when)	Nebulizer or Inhaler?	Special Instructions

Parent consent for management of health condition while at school or other school related activities

I, the parent/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. Furthermore, I agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
5. School staff interacting directly with my child may be informed about this health care plan.
6. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.
7. 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/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the 2017/2018 school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____