This page to be completed by Parent/Guardian

Student Name _____ School Year_____

Child's Picture

Warren Woods Public Schools

Asthma School Health Plan

Student Name_____

Date of Birth _____ Age_____ Grade ___ School_____

Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.

CONTACT INFORMATION

	Call First	**Try Second**
Parent/ Guardian:	Name:_____	Name:_____
	Relationship: _____	Relationship: _____
Phone:	Home: _____	Home: _____
	Cell: _____	Cell: _____
	Work: _____	Work: _____

Call Third (If Parent/guardian cannot be reached)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Asthma History

Asthma Triggers (exercise, cold, foods, etc.) _____

Equipment (check all that apply): Medication __ Inhaler __
Spacer __ Nebulizer __ Peak Flow Meter__

If my child is to carry an inhaler, I will also supply the school office with a back up inhaler
___Yes ___ No

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having asthma to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered for asthma and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Sources: Michigan State Board of Education Policy on the Management of Asthma in Schools, Thomas F. Plaut, M.D. Asthma Emergency Guide, School Guidelines for the Nurse in the School Setting-Illinois Emergency Medical Services for Children

This page to be reviewed & signed by Physician/Prescriber

Student Name _____ School Year_____

Signs of Asthma Attack

- Wheezing
- Shortness of breath
- Difficulty breathing
- Prolonged coughing
- Complains of chest tightness or pressure
- Anxious appearance
- Inability to speak in a full sentence without taking a breath, or only able to whisper
- Need to stand or lean over at waist
- Peak Flow reading below 80% of personal best

Action

- Allow student to use his/her medication as ordered below
- Use a spacer if provided for a metered dose inhaler
- Be sure to wait 1-2 minutes before a second puff of the inhaler
- Remain calm
- Encourage slow, deep breathing: in through the nose & out through puckered lips
- Have student sits upright
- Stay with the student until breathing normally
- Contact parent

If no medication is available:

- Continuously observe student
- Notify parent to provide medical care
- Call 911 as indicated below

Signs of Asthma EMERGENCY

- No improvement 10-15 minutes after medication is given
- Breathing difficulty gets worse
- Skin pulls in around collarbone or ribs with each breath(shoulders may rise)
- Looks anxious, frightened, or restless
- Stops playing and cannot start activity again
- Trouble walking or talking
- Hunched over
- Lips or tips of fingers (nail beds) are blue or gray
- Peak flow reading less that 50% of personal best

Action

- CALL 911 and Parent/Guardian
- Repeat medication while waiting for emergency help to arrive
- Start CPR if breathing stops

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication: _____ Route __ MDI (Metered Dose Inhaler) Dose: _____
__ Nebulizer (Breathing Machine) Dose: _____

MDI Treatment may be repeated in 5 to 10 minutes if no help or symptoms worse __Yes _ No

Nebulizer instructions_____

Medication is needed 20 minutes before PE/recess/strenuous exercise __ Yes __No

Student can use inhaler correctly, knows when to get adult help, not to share, and how to properly maintain the device. Therefore in my professional opinion, this student should be allowed to self carry their inhaler. __ Yes __ No

Peak Flow Readings are to be done at school __ Yes __ No Give Medication for a PF Reading below _____
Personal Best Peak Flow_____
Other instructions/orders _____

Physician/Licensed Prescriber Name _____

Phone Number _____ Fax Number _____

Signature _____ Date _____