WARRIOR RUN SCHOOL DISTRICT

Dr. Alan J. Hack, Superintendent
4800 Susquehanna Trail
Turbotville, PA 17772
570-649-5138

Dear Parent (s) / Guardian (s):

Enclosed is a School Asthma Management Plan. Please take a few minutes to complete this important form. Although asthma is controllable, it can be very serious. This plan is to ensure your child receives the best care possible while he/she is in school.

Also, for parents who request that their child be allowed to carry their inhaler: School policy dictates that *"request to carry and self-administer medication, such as an inhaler, must be accompanied by a licensed person's written order stating such, a parent's written request, and demonstration of the child proving competence to self-medicate. The child shall notify the nurse whenever the medication is used. The school is not responsible for ensuring that the medication is taken. Misuse of medications that are self-administered will result in immediate confiscation of the medication, loss of this privilege, and disciplinary action as outlined in the drug policy."*

Please return the enclosed asthma plan to the nurse's office as soon as possible. Also, please return the enclosed medication form if an inhaler or nebulizer treatment is required at school. Requests to carry and self-administer an inhaler at school **must be written** on this medication form.

Also, please notify your school nurse if your child has "outgrown" their asthma. A parent's input on their child's health is important. With your cooperation, we can work together in controlling your child's asthma. Thank you for your time and assistance.

Sincerely,

Health Room Nurses

2 Enclosures

Elementary School
301 Pine Street
Turbotville PA, 17772
570-649-5164

Middle School
4860 Susquehanna Trail
Turbotville PA, 17772
570-649-5135

High School
4800 Susquehanna Trail
Turbotville PA, 17772
570-649-5166

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School Asthma Management Plan

Student Asthma Action Form

Name:_____ Grade:_____ Age:_____Bus #:_____

Teacher: _____ Room:_____

Parent/Guardian Name: _____ Ph (H):_____
Address:_____ Ph(W): _____

Parent/Guardian Name:_____ Ph (H):_____
Address: _____ Ph(W):_____

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician:_____ Ph:_____

Daily Asthma Management Plan

Identify the things, which start an asthma episode (check each that applies to the student):

_____Exercise _____Strong Odors _____Other

_____Respiratory infections _____Chalk dust _____Food

_____Change in temperature _____Carpets in rooms _____Molds

_____Animals _____Pollens

Comments:_____

Control of School Environment
(List any environmental control measures; pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)_____
_____
_____

Peak Flow Monitoring (if applicable)
Personal Best Peak Flow Number: _____

Monitoring Times: _____ _____

Daily Medication Plan

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

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School Asthma Management Plan (continued)

Emergency Plan
Emergency action is necessary when the student has symptoms such as _____
_____ or has a peak flow reading of _____.

Steps to take during asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if _____
_____
3. Contact parent if _____
4. **Seek emergency medical care (911) if the student has any of the following:**

No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.

Peak flow of _____.

Hard time breathing:

1. Chest and neck are pulled in with breathing.
2. Child is hunched over.
3. Child is struggling to breathe.

Trouble walking and talking.
Stops playing and can't start activity again.
Lips or fingernails are gray or blue.

Emergency Asthma Medications

	Name	Amount	When to use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments / Special Instructions_____

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* This form is accurate and complete to best of my knowledge.
* This School Asthma Management Plan may be shared with the student's teacher(s).
* This School Asthma Management Plan may be shared with the student's bus driver.

_____ _____
Date Parent Signature

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