Lee County Schools / Student Health Services

ASTHMA CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 229-903-3568.

Student Name _____ D.O.B _____Teacher _____
School Year _____

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 _____
▫Animals _____	▫Pollens	
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 Student's Personal Best Peak Flow Number: _____ Monitoring Times: _____		

DAILY and RESCUE ASTHMA MEDICATIONS

√ ***Given at School***	***Medication Name***	***Dosage (amount)/Time***	***When to Use***

COMMENTS/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.

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

I, this child's parent/guardian, hereby authorize the named Health Care Provider who has attended to my child, to furnish to the School Nurse Coordinator 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 Portability 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 Lee County Schools. This authorization expires as of the last day of the school year.
I also agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an inhaler.

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