SCHOOL HEALTH CARE PLAN

BLUFFTON-HARRISON MSD

DIAGNOSIS: ASTHMA

Name_____ Grade_____ DOB_____

Does your student have allergies? YES_____ NO _____

What triggers an asthma episode? (check all that apply)

Exercise___ Animals___ Pollen___ Mold___ Dust___

Respiratory infections___ Change in temperature___ Strong odors/fumes___

Food_____ Other_____

Early symptoms of an asthma episode (check all that apply)

Runny nose___ Coughing___ Itchy throat___ Sneezing___ Wheezing___

Tightness in chest___ Irritability___ Shortness of breath___

Other_____

Does your student have any activity restrictions? YES_____ (health care provider note needed) NO____

Has your student been hospitalized for an asthma episode? YES____ (when)_____ NO_____

Does your student recognize early symptoms of his/her asthma episodes? YES_____ NO_____

Will a peak flow meter be used during school hours? YES____ (medical authorization needed) NO_____

MEDICATIONS:

Medication_____Dosage/Frequency_____

Medication_____Dosage/Frequency_____

Medication_____Dosage/Frequency_____

NOTE: If your student needs to carry and self-administer an inhaler during school hours/events, a corporation MEDICATION PERMISSION FORM must be completed by the physician who prescribes the inhaler. This form must be renewed annually and given to your student's building nurse.

EMERGENCY PLAN:

Steps to take during an asthma episode:

Check peak flow, if authorized by health care provider

Give medication as authorized by health care provider

If student does not improve within 15-20 minutes, notify parent

Seek emergency medical care if the student has any of the following:

Cough constantly

No improvement 15-20 min. after initial treatment

Continued difficulty breathing

Difficulty walking or talking

Lips or fingernail blue/gray in color

EMERGENCY CONTACTS:

Name_____Relationship_____

Phone Number(s)_____

Name_____Relationship_____

Phone Number(s)_____

Name_____Relationship_____

Phone Number(s)_____

PHYSICIAN NAME:_____

Phone Number(s)_____

Preferred Medical Facility_____

I hereby give permission for this careplan to be shared with appropriate school staff.

Parent/Guardian signature_____Date_____

School Nurse signature_____Date_____