ASTHMA CARE PLAN

Student Name: _____ **DOB:** _____

Diagnosis: _____

Triggers: _____

MEDICATIONS TO BE GIVEN AT SCHOOL

If peak flow available: use inhaler if _____

Quick Relief Inhaler: _____

☐Use with spacer

_____puffs every_____ hours as needed for cough, wheezing, or shortness of breath.

☐ Use 5-10 minutes before exercise

☐ Repeat if not improved in _____ minutes

Other Medications:_____

☐Student to **carry medication and self-administer** and

- This health care provider has confirmed that the student is capable of appropriate self-administration of the above medication, **and,**
- If student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication.

FOR SCHOOL USE:

Expiration date of inhaler: _____ (use pencil)

□ School to store medication in _____

□ Notify parent/guardian with time inhaler used for quick relief.

Call parent/guardian if not improved after above treatment.

MEDICAL ALERT*

- Rapid breathing
- Not having enough breath to speak
- Persistent cough or wheeze.
- Decreased level of consciousness.
- Flared nostrils, tight neck muscles, sitting hunched forward.

***** Call parent +/or 9-1-1 if these symptoms are present.**

CLINIC/PROVIDER STAMP

My signature below provides authorization for the above orders.

All procedures will be accordance with state laws and regulation. This authorization is valid for one year.

Health Care Provider Signature: _____ **Date**: _____

Parental Consent for Asthma Management in School

As the parent or guardian of the above named student, I request that the school assist with the above medication as directed above and in accordance with all state laws and regulations. The school nurse may communicate with the above health care provider about this student when necessary. (Ed Code section 49423 and 49480).

Parents/ Guardians must:

- Provide the necessary equipment (inhaler, spacer, etc.). The inhaler should be in the original packaging.
- Notify the school of any changes in student's health or medication plan.
- Notify the school immediately of any change in health care provider authorization.

Parent /Guardian Name:_____**Signature:**_____ **Date:**_____

Student Contract for Carrying Own Medication: I, _____will be responsible for carrying, administering, and keeping safe at all time, my asthma medication. I will use the asthma medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.