WEBSTER GROVES SCHOOL DISTRICT – **ASTHMA MEDICAL ORDERS / CARE PLAN – School year: 2017-2018**

STUDENT'S NAME:		Date of Birth:
School:	Grade:	
Doctor Name:	Phone#:	Fax#:
Transportation to/from school: ☐ Walk	☐ Car	☐ Bus #_____
Physical Education – Days and Time or Period:		
Medications taken at home:		

LICENSED HEALTH PROFESSIONAL – DAILY ASTHMA MANAGEMENT PLAN
(Must be completed by licensed health professional)

Identify asthma triggers: *(Check each that applies to this student)*

☐ Exercise ☐ Pollens ☐ Molds ☐ Respiratory Infections ☐ Change in Temperature/Season

☐ Other:_____ Personal best peak flow:_____

****Warning signs of an Asthma Episode**:_____

ROUTINE medication to be given at school. If more than one medication is to be given, list in order to be given.

Medication	Amount	When to use
1.		
2.		

SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement 15-20 minutes after initial treatment with medication and a parent/emergency contact cannot be reach, or if condition worsens during this period
- Peak flow less than _____
- Difficulty walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue
- Difficulty breathing with:
  - **Chest and neck pulled in with breathing**
  - **Child is hunched over**
  - **Child is struggling to breathe**

Inhaler kept in:

□Office

□Backpack

EMERGENCY ASTHMA MEDICATION

Medication	**Amount**	**When to Use**	**Route**
1.			
Side Effects:			

Time interval for repeating dosage:

- **If symptoms not relieved after initial dose:**
- **If symptoms reoccur before next dose is due:**

It is my professional opinion that this student (circle one) **SHOULD/SHOULD NOT** carry and use his/her rescue medication/s/ by himself/herself at school. I have instructed this student in the proper way to use these medications.

****He/she has successfully demonstrated the ability to self-administer. ☐Yes ☐No ☐ Unable ---why_____**

LHP Signature	**Date**	**Phone#**
Printed Name	**Start Date: 9/1/2017**	**End Date: 6/30/2018**

PARENT/GUARDIAN SECTION

Parent Name:	Parent Name:	Emergency Contact:
Home #:	Home #:	Home #:
Work #:	Work #:	Work #:
Cell #:	Cell #:	Cell #:

Parent's signature gives permission for the administration of the above ordered medication at school by authorized personnel, and gives permission for the school designee to communicate freely with the licensed health care provider.

_____ *Parent/Guardian Signature Required*

***Permission to carry and self-administer inhaler:* **Yes / No** *(Circle one)*