Asthma Management & Emergency Plan

RN verified ____________________

Student____ Grade_______________ Date_______________

Date of Birth______________ School________________________ Teacher________________________

Emergency Contacts

Name___________________________ Number_________________ Relationship__________________

Name___________________________ Number_________________ Relationship__________________

Will your student take asthma medication at school?

- ☐ Yes
- ☐ No–**If no, I understand that if difficulty breathing occurs, 911 will be called.**

This student needs supervision and/or assistance with administration of asthma medication.

- ☐ Yes
- ☐ No

Section 1: Prescription Medications (Provider Signature Required On Page 2)

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

Route = oral, inhaled, topical, injectable, etc.* ***All medications administered by AASD staff are only available to students during school hours (7:30 a.m.- 4:00 pm), must not be expired, and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any additional labels or containers.*

What triggers your student's asthma?

- ☐ Illness
- ☐ Exercise
- ☐ Allergies
- ☐ Cold Air
- ☐ Other (explain) ____

Describe your student's usual asthma symptoms:

- ☐ Coughing
- ☐ Shortness of breath
- ☐ Nervous
- ☐ Weakness
- ☐ Itchy throat
- ☐ Chest tightness
- ☐ Other (explain) ____

If your student doesn't improve within 10-15 minutes after using inhaler/nebulizer, what steps should school staff take?

- ☐ Contact Parent
- ☐ Repeat treatment
- ☐ Call 911 - **Hospital of choice**____

Additional Comments:

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Parent Consent For Management Of Health Condition While At School Or Other School Related Activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature______________________________________Date______________

Provider Information/Consent (Provider only needs to sign if student has medication to be given at school)

Print Name of Provider______________________________Clinic Name_____________________

Phone Number__________________________________Fax Number_____________________

Address____

Signature of Provider____ Date_____________

Is the student authorized to carry and self-administer prescription medication? Yes or No (Circle One)
If yes, where will this prescription medication be kept? ☐Backpack ☐Locker ☐Other______________
Please attach student's Asthma Action Plan if applicable.

I agree to allow my student to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year. *Controlled substances may not be transported by students.* ☐ Yes ☐ No

**Note to Health Care Provider - This document serves as medication and treatment orders.*