RANKIN COUNTY SCHOOL DISTRICT SCHOOL ASTHMA HEALTH PLAN

DATE RECEIVED ____ / ____ / ____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name ____ Age ____ Date of Birth ____

School ____ Teacher ____ Grade ____

Emergency Contact Name ____ Phone ____

IMPAIRMENT

Severity of Asthma ☐ Mild ☐ Moderate ☐ Severe Diagnosis Date ____

Brief Description:

List frequency and duration of episodes:

List all symptoms related to the acute episodes/flare ups:

List instructions if coughing or wheezing occurs:

List any known triggers of acute episodes/flare ups:

List any restrictions student must follow while at school:

List asthma medications (dosage, delivery method, and frequency):

A Consent for Medication at School form (in addition to this form) is required for medications to be administered at school.

TO BE COMPLETED BY THE SCHOOL WITH PARENT/GUARDIAN

STUDENT/GUARDIAN WILL:

1. Avoid known allergens and asthma triggers.
2. Take all prescribed medications and follow the plan of care.
3. Follow up with health care provider as appropriate.
4. Alert school staff immediately of any asthma symptoms.

SCHOOL WILL:

1. Maintain student safety by removing known allergens as appropriate.
2. Notify the administration, and parent or guardian, if an asthma attack occurs.
3. Administer medications per Medication Consent Form approved by health care provider.
4. Call parent and 911, if needed.

Health Care Provider - Name (Print)	Health Care Provider - Signature
Parent/Guardian - Name (Print)	Parent/Guardian - Signature
School Representative - Name (Print)	School Representative - Signature