ASTHMA HEALTH CARE PLAN

Student's Name_____School Year_____

School_____ Grade_____ Date of Birth_____

Parent's Name (call first)_____

Home Telephone_____Work_____Cell_____

Parent's Name/Emergency Contact(call second)_____

Home Telephone_____Work_____Cell_____

Physician_____Phone_____Preferred Hospital_____

These triggers have caused my child to have an asthma episode:

___Exercise ___Respiratory infections ___Change in temperature ___Cold air
___Pollens ___Strong odors ___Animals ___Dust
___Allergies ___Mold ___Food:_____Other:_____

My child has these signs and symptoms with an asthma episode:

___Coughing ___Wheezing ___Difficulty Breathing ___Other:_____

Asthma Management:

Green Zone: No symptoms

- Breathing is good
- No cough or wheeze
- Can do normal activities

Yellow Zone: Rescue medicine needs to be taken

- Cough
- Wheeze, shortness of breath
- Tightness in chest

Red Zone: Danger – call parent and 911 as necessary

- Medicine is not working
- Breathing is hard and fast
- Nose opens wide
- Trouble walking and talking

Steps to take during an asthma episode:

1. Give rescue inhaler as prescribed.
2. Have student return to class if symptoms improve or in the green zone.
3. Contact parent if symptoms do not improve and child's health status has not returned to green zone .
4. Call 911 if:
   - Has no improvement in moderate to severe asthma symptoms 15-20 minutes after giving medication and parent/guardian cannot be reached.
   - Breathing is difficult with these symptoms: Chest and neck pulls in with breathing. Child is struggling to breathe.
   - Lip color changes to blue or white.
   - Nail beds are grey or blue.
   - Child has trouble walking or talking due to asthma.

Current medication(s): Name of Medication Frequency/Dosage/Time given

_____ _____
_____ _____
_____ _____

Are any of the mediations administered at school?

No_____ Yes____ If yes, prescription medication form must be completed.

_____Date _____
Signature of Parent/Legal Guardian

_____Date_____
Signature of Physician

Prescription Medication at School

Parental consent

Student Name_____ School_____Fax#:_____

I request and authorize that my child, _____received medication from a school staff member appointed by the school principal.

I shall supply a properly labeled medication. The label shall include the name and telephone number of the pharmacy, the name of the student, the name of the prescribing physician, the name of the medication, the medication's storage requirements and the dosage to be given. I understand that the school is not responsible for the loss of medication due to the carelessness on the part of the student.

Students are not permitted self-administer or carry medication, except asthma inhalers, insulin or an epi-pen as prescribed by their physician.

I agree to hold the New Berlin School District harmless in any and all claims arising from the benefits or consequences of this medication which the physician has prescribed and my child has taken. Furthermore, I agree to hold the district harmless of any responsibility for assuring that the medication is taken.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

I authorize the prescribing physician of this medication to disclose by any means (including written, oral, or electronic means) the information necessary to administer this medication to New Berlin Public School employee administering the medication.

_____ _____

Date Signature of Parent/Legal Guardian

Physician's Order for Prescription Medication

Date effective _____to _____

Student Name_____ Birthdate_____

Name of Medication_____ Purpose_____

Dosage_____ Route: _____

Frequency/Administration time _____

Possible side effects to be observed:_____

If PRN medication, to be given for what symptoms?_____

Self-Administration is only permitted for **Epi-Pens, Insulin, and Asthma Inhalers**. If authorization is for one of these medications, is it safe for this child to carry and self-administer this medication?

_____**Yes**, the patient/student has been instructed on the use of this medication and is capable of self administration.
The medication will be kept: ____backpack ___locker _____other:_____

_____**No**, It is my professional opinion that _____should **NOT** carry his/her medication by him/herself. Medication will be kept in the school office/health room.

I am willing to accept direct communication from the person dispensing or administering the medication.

_____ _____ _____

Signature of Prescribing Physician Telephone Number Date