Wrightstown Community School District

Student Health Services
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Asthma Management Plan for School Year: _____

Student Name _____ Date of Birth _____

School Building _____ Teacher _____Grade _____

Parent/Guardian Name and Phone Number(s)_____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

Section 1. EMERGENCY ASTHMA PLAN

Symptoms of asthma requiring intervention:

- Shortness of breath
- Excessive coughing
- Wheezing
- Chest tightness
- Cannot catch breath
- Anxiety/nervousness
- Peak flow of _____
- Other:_____

SEVERE/EMERGENCY symptoms of asthma:

- Failure of medication to reduce symptoms/worsening symptoms after 15-20 minutes
- Coughs constantly
- Inability to speak in complete sentences without taking a breath
- Sits hunched over (stooped body posture)
- Nasal flaring
- Neck/chest pull in during breathing
- Blueish or grey lips or fingernails
- Peak flow of _____
- Pulse oximeter reading of less than 90%
- Decrease or loss of consciousness
- Difficulty walking or talking

Instructions to follow if asthma symptoms occur at school:

1. Stop activity/remove student from aggravating factor
2. Have student sit in upright position
3. Check peak flow if possible
4. Give emergency medications as listed in plan
5. Stay with student and observe for worsening/not improving symptoms
6. Notify parent/guardian or emergency contact
7. Re-check peak flow if possible
8. Other_____

If symptoms worsen or do not improve after 10-15 minutes, follow directions for severe/emergency asthma symptoms.

Instructions to follow for SEVERE/EMERGENCY asthma symptoms occur at school:

1. Call 911
2. Administer emergency medications as listed in plan if timing is appropriate (monitor for appropriate timing between doses/if meds can be repeated)
3. Notify parent/guardian or emergency contact
4. Other_____

EMERGENCY Asthma Medications to be taken at school (please put in chart in correct order to administer, be sure to specify the amount of time between doses or if the medication dosage cannot be repeated).

Medication Name	Dose (amount)	Frequency/Timing (how often/when)	Nebulizer or Inhaler?	Special Instructions/Negative Side effects

-Turn Over-

Section 2: Daily/Preventative Asthma Plan

Identify triggers which can cause asthma symptoms:_____

***If student will require using an inhaler to prevent asthma symptoms please fill in the daily chart and specify when/under what conditions it will be needed (for example: before gym class).**

DAILY Inhaled Asthma Medications to be taken at school as a preventative measure (please put in chart in correct order to administer).

Medication Name	Dose (amount)	Frequency/Timing (how often/when)	Nebulizer or Inhaler?	Special Instructions/ Negative Side effects

Parent consent for management of health condition while at school or other school-sponsored activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment, including medication in the original. pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
6. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition.
7. School staff interacting directly with my child may be informed about this health care plan.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. Hold without liability the Wrightstown Community School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the pertaining school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

☐ **ONLY FOR STUDENTS IN 5th GRADE AND UP** I have instructed the student in the proper way to use his/her medications. **It is my opinion that he/she should be allowed to carry and administer inhaled medication by him/herself.**

☐ **It is my opinion that the student should not carry nor administer his/her inhaled medication by him/herself.**

Signature of Provider_____ Date_____

School RN Signature _____ Date_____