M.S.D. Student Health Services

MNE Fax: 260-569-6838 **SCE Fax: 260-569-6841 SES** **Fax: 260-569-6842**
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School Year_____

STUDENT HEALTH SERVICES
PLAN OF CARE - ASTHMA

Student Name: _____ D.O.B. _____ GRADE:_____
Last Name First MI

Parent /Guardian Name:_____Home phone #: _____ Work #: _____ Cell #:_____

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician seen for asthma: _____
Name Phone

Family Physician: _____
Name Phone

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode. (Check each that applies to the student)**

☐ Exercise ☐ Strong odors or fumes ☐ Other _____
☐ Respiratory infections ☐ Chalk dust
☐ Change in temperature ☐ Carpets in the room
☐ Animals ☐ Pollens
☐ Food ☐ Molds

Comments _____

- **Control of School Environment**

(List any environment control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____
_____

- **Peak Flow Monitoring**

Personal best peak flow number _____
Monitoring times _____

- **Daily Medication Plan**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Name of inhaler: _____ **Kept at school:** Yes _____ No _____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____

_____, or has a peak flow reading of _____.

- **Steps to take during an asthma episode:**
  1. **Give medications as listed below:** _____
     _____
  2. **Have student return to classroom if** _____
  3. **Contact parent if** _____
  4. **Seek emergency medical care if the student has any of the following:**
     - ✓**No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached**
     - ✓**Peak flow of** _____
     - ✓**Hard time breathing with:**
       - Chest and neck pulled in with breathing
       - Child is hunched over
       - Child is struggling to breathe
     - ✓**Trouble walking or talking**
     - ✓**Stops playing and can't start activity again**
     - ✓**Lips or fingernails are gray or blue**

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

- **Emergency Asthma Medications**

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments / Special Instructions:

_____
_____

- **For Inhaled Medications**
  - ☐ **I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ *should be allowed* to carry and use inhaled medication by him/herself.**
  - ☐ **It is my professional opinion that _____ *should not carry* his/her inhaled medication by him/herself.**

Physician's printed name | Physician's Signature | Phone # | Date

Printed name of parent or guardian | Signature | Phone # | Date