LANDER COUNTY SCHOOL DISTRIC ASTHMA MANAGEMENT PLAN

Name:_____ DOB:_____ Grade/Teacher:_____

TO BE COMPLETED BY PARENT/GUARDIAN

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse. I request treatment be administered in accordance with my child's licensed healthcare provider's orders. I will notify the school if my child's health status changes or we change healthcare providers. I agree to provide all necessary equipment and supplies properly labeled.

***My child may carry/use his/her: (Inhaled asthma medicine: ☐Yes ☐No) (Epi-Pen: ☐Yes ☐No)**

Parent/Guardian Signature:_____

Telephone number: Home_____ Work_____ Cell _____

Physician/Healthcare Provider Name:_____

TO BE COMPLETED BY STUDENT'S PHYSICIAN/HEALTHCARE PROVIDER

Provider name_____ Phone_____ Fax_____

MEDICATIONS

Preventive (Controller) Medications:_____

Quick Relief Medications: (check the appropriate quick relief med, circle device, list dose/frequency):

☐Albuterol (Proventil, Ventolin) ☐Pirbuterol (Maxair) ☐Other:_____

*Inhaler with : ☐Spacer OR ☐Nebulizer * Dose/Frequency_____

ALLERGIES/TRIGGERS for ASTHMA: ☐Exercise ☐Pollens ☐Cold Air ☐Animals ☐Environmental Irritants

☐Respiratory Illness ☐None Known ☐Other_____

EXERCISE PreTREATMENT INSTRUCTIONS *(Check all that apply)*

☐Give 2 puffs of quick relief inhaler 15 minutes prior to recess/physical education and/or_____

☐May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or _____

☐Measure Peak Flow prior to recess/physical education; restrict aerobic activity when child's peak flow is below_____

☐Other_____

ASTHMA EXACERBATION TREATMENT INSTRUCTIONS:

▶ *YELLOW ZONE:*

☐Give 2 puffs of quick relief inhaler with spacer (or nebulizer treatment). May be repeated in 10 minutes if doesn't recover to Green Zone. Notify parents of exacerbation.

☐Other_____

▶ *RED ZONE:* If child is in respiratory distress, and/or peak flow is in RED ZONE:

☐**Call 911.** Give 4 puffs quick relief inhaler (or nebulizer treatment), and call parent.

☐Other_____

*Nevada law permits students to carry and use inhaled medications and Epi-pen after demonstrating appropriate use of inhaler/epi-pen. Please check appropriate boxes below:

☐This student has the knowledge and skill to carry and use: ☐Inhaler medication ☐Epi-Pen

☐This student in NOT able to carry and use by him/herself: ☐Inhaler medication ☐Epi-Pen

☐Please contact Healthcare Provider and parent if student is using quick relief medicines more than 2 times a week (with the exception to pre-exercise treatment).

Other:_____

Healthcare Provider Signature_____Date_____

TO BE COMPLETED BY SCHOOL NURSE

This student demonstrates knowledge and skill to carry and use:

Inhaler: ☐Yes ☐No Epi-Pen: ☐Yes ☐No

_____

School Nurse Signature Date