ASTHMA MEDICAL MANAGEMENT PLAN

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained personnel, and other authorized personnel.

Student's Name: ____

Date of Birth: ____________________________ Grade: _________________ ID #: ______________

School: ____ Teacher: _______________________________

Age at on set: ___________________________

Contact Information

Mother/Guardian: ____

Telephone: Home _________________________ Work ____________________ Cell___________________

Father/Guardian: ____

Telephone: Home _________________________ Work ____________________ Cell __________________

Student's Doctor/Health Care Provider: ____

Address: ____

Telephone: _________________________ Emergency Number: _____________________________________

Other Emergency Contacts (Relationship):____

Telephone: Home __________________ Work __________________ Cell ___________________________

Asthma Triggers: (circle those that apply

Animals	Insect Sting/Bee	Chalk Dust	Weather Change
Dust Mites	Exercise	Latex	Molds
Pollens	Respiratory Illness	Smoke	Strong Odors
Foods:		Other:	

If Exercise: Pre-medication (dose and frequency) ____

Exercise medifications ____

Asthma Episode Indicators:

- Shortness of breath – especially with exertion
- Wheezing – a whistling or hissing sound when breathing out
- Coughing – may occur after exercise or when exposed to cold, dry air
- Chest tightness – may occur with or without the above symptoms
- **Indicators specific to THIS STUDENT:** ____
  ____

Steps to take during an asthma episode:

- Notify school health office ____
- Remove student from any obvious trigger, escort student to the health office if possible.
- **DO NOT** leave the student alone
- Sit student comfortably leaning forward, **DO NOT** insist that they lie down.
- Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5 – 10 minutes after use if inhaler.
- Contact parent/guardian to make aware of asthma episode and effectiveness of treatment.
- If symptoms **DID NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency.
- **Interventions specific to THIS STUDENT:** ____
  ____
  ____

Steps to take during an asthma emergency:

An asthma emergency is noted when initial treatment is **NOT** Effective **OR** when any of the following symptoms are present.

- Rapid, shallow breathing
- Chest and neck pulled in with breathing
- Retracting of abdominal muscles
- Nostrils flaring
- Hunched over
- Struggling to breathe
- Trouble walking or talking
- Lips or fingernails are gray or blue
- Pale and/or sweating
- Student is unconscious

Call 911

Administer emergency asthma medications as per medication orders

Contact parent/guardian regarding severity of student's asthma episode and urgent need for evaluation by medical doctor.

Parent/guardian/emergency contact must arrive within 10 minutes to take student to medical facility or 9-1-1 will be called for medical evaluation of the student and possible emergency transport to a medical facility. A copy of this Asthma Care Plan and the student's Emergency Card **MUST** be give to transport personnel.

Medicine	Dose	Route	Frequency	Duration	Side effects to be reported to Physician

Medication/Inhaler is kept in Health Office? ____ Yes ____ No
No Medication is kept at school: ____ Yes ____ No
Does student self carry a rescue inhaler? ____ Yes ____ No
If Yes:

________________________ has been instructed in the proper use of ____________________ inhaler.
(Child's name) (Name of inhaler)

We, ______________________________ and ________________________________ request that
(Practitioner) (Parent/Guardian)

___________________________ be permitted to carry the inhaler on his/her person or to keep same in
(Child's name)
his/her locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of his/her inhaler.

______________________________________ ____________________
Physician's Signature Date

This Asthma Medical Management Plan has been approved by:

____ _____________________________

Student's Physician Signature Date

I hereby agree to give my permission to the school nurse/principal to contact the child's practitioner in regard to this plan and/or medication. I further agree to hold the Middleton-Cross Plains Area School District and the identified person(s) harmless in any or all claims arising from the administration of any medications given at school. I agree to notify the school in writing when any changes in the above order are necessary. I also consent to the release of the information contained in this Asthma Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

____ _____________________________

Student's Parent/Guardian Signature Date

____ _____________________________

School Nurse Signature Date

____ _____________________________

Health Assistant Signature Date

Start Date: ______________________________ Stop Date: __________________________