ASTHMA SCHOOL MEDICATION PLAN

Student Name:_______________________________ Birthdate: __________

School Name: _______________________________ Grade/Rm. __________

Emergency Contact Information and Parent / Guardian Information:

Parent / Guardian-1 (name / relationship)**:** _______________________________

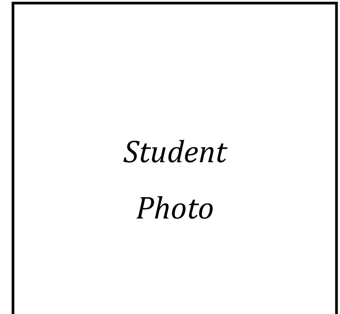
Phone (H) ______________________ Tel (W) ______________________

Parent / Guardian-2 (name / relationship)**:** _______________________________

Phone (H) ______________________ Tel (W) ______________________

Healthcare Provider ______________________ Phone: ______________

Asthma Specialist: ______________________ Phone: ______________



Student Photo

Emergency contact if other than above (name/relationship): ______________________ Phone: ______________

Diagnosis / Reason for Medication:	___Asthma ___ Other:
Asthma Triggers to Avoid for student while at school:	__Smoke / fumes __ Animal __Mold Spores __ Dust Mite Other:

YES / NO: Student is required to have quick relief asthma medication at school to provide rapid relief of asthma symptoms if needed: **cough, chest tightness, wheezing, trouble breathing, shortness of breath**

YES / NO: Student is required to use quick relief asthma medication BEFORE gym or other exercise to prevent exercise induced bronchospasm from asthma

YES / NO: Student is required to take daily asthma control medication at school as directed

Medication Information					
Name of Medication	**YES / NO: Albuterol**		**Other:**		
Form of Medication	____Inhaler	____Nebulizer	____Dry Powder Inhaler	____ Liquid	____Pill / Capsule
Dosage of Medication	Number of puffs ______________		Other: ______________________		
Other instructions:	YES / NO: Inhaler MUST be used with a spacer (valved holding chamber) for administration YES / NO: Please maintain a written record (Log) of all doses: YES / NO				
When to administer dose	YES / NO: 5-15 minutes before gym, recess, or exercise to prevent exercise induced bronchospasm YES / NO: As needed for FAST RELIEF of chest tightness, shortness of breath, wheezing or prolonged cough or other asthma symptoms. A total of 3 doses can be given within an 8 hour interval YES / NO: Daily at __________ AM / PM for daily asthma control (long term prevention)				
Repeat Dose	______: DO NOT REPEAT the dose ______: Repeat dose one time if symptoms **not** gone 10 minutes after first dose AND repeat dose every 3-4 hours IF symptoms RECUR during the school day				
When to call Child's Parent	If after 2 consecutive doses (2-4 puffs per dose) are given and there is no improvement in symptoms, please seek further medical attention and call parent				
When to call Child's Physician	If you have concerns or questions about the student's medication or disease				
Asthma Emergency The steps that should be taken: •Activate the emergency medical system in your area. Call 911. •Call Parent/Guardian and/or Healthcare Provider	The following are possible signs of an asthma emergency: •Difficulty breathing, walking, or talking •Blue or gray discoloration of the lips or fingernails •Failure of medication to reduce worsening symptoms.				

Supervision of Medication	____ Student is permitted to carry medication and self-administer with no supervision ____ Student MAY self-administer medication BUT supervision is required for all doses ____ Student requires trained assistance to administer all doses		
Expected Normal side effects:	___None	____Fast heartbeat, tremor, hyper-activity	Other:
Storage Requirements	___None	____Refrigerate	Other

START Date to begin Medication	____When school receives form	Other:
STOP Date to discontinue Medication	____End of school year	Other:
Instructions for proper use of medicine are attached to this form	___YES	___NO

PLEASE COMPLETE SECTION BELOW FOR STUDENT PERMISSION TO CARRY INHALER

**************SELF-MEDICATION FOR ASTHMA INHALERS**************

Authorization (In accordance with ORC 3313.716/3313.14)

Who keeps the bronchodilator inhaler at school?

School policy restricting possession of medication by students is insufficient grounds for preventing students with sufficient maturity from retaining possession of their bronchodilator inhaler. Such policies, when enforced, delay appropriate treatment and restrict activities unnecessarily. The decision regarding sufficient maturity of the student to be responsible for appropriate inhaler use is an individual one to be made by the parents in consultation with their physician. The inhalers pose no abuse potential or other danger to classmates. While restrictions on bronchodilator inhaler possession may be necessary for the youngest students, it constitutes unreasonable interference with the student's medical care for school personnel to unilaterally restrict possession of bronchodilator inhalers by students judged by parents and physician to have sufficient maturity to use the device appropriately. Possession of the bronchodilator inhaler by the student also promotes earlier use that decreases the risk of requiring emergency care from rapidly progressive asthma, which on rare occasion can cause hypoxia, brain damage, and death. Discussion among parents, physician, and school personnel can determine whether school-supervised administration would improve or deter compliance.

_____ **Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF-MEDICATE at school.**

Student Agreement and Signature:

I, ____, agree that I will:

Never allow another student to use my medication.

Keep my medication with me at all times.

Go to the School Clinic, accompanied by someone, when I used my rescue inhaler and continue to have symptoms.

Follow school policy and my medical provider's instructions as outlined in my Asthma Medication Plan.

Student Signature:____**Date:**______________________

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Signature of Parent/Guardian ____________________________________ **Date** ________________

Signature of Prescriber ____ **Date** ________________

Copies must be provided to the principal and to the nurse.