ASTHMA TREATMENT PLAN – Physician's Orders

Name:_____ **Grade**_____ **DOB** ___/___/____

Triggers

___Strong odors or fumes	___Exercise	___Pollens	___Dust
___Respiratory infection	___Carpets	___Animals	___Molds
___Change in temperature	___Foods	___Other_____	

Comments/P.E. Restrictions:_____

_____

Peak Flow Monitoring-Personal Best_____

Daily Medication Plan

	Medication	Dose	Frequency	May self-administer
1.				___yes ___no
2.				___yes ___no

Action Plan: When Symptoms Start

With exposure to trigger or cold symptoms, mild wheeze, tight chest, cough, and/or peak flow from _____to_____: Continue with above medication and add:

	Medication	Dose	Frequency	May self-administer
1.				___yes ___no
2.				___yes ___no

Emergency Plan: When Symptoms Persist or Worsen

If medicine is not helping within 15-20 minutes, breathing is hard and fast, nose opens wide, ribs show, lips/fingernails blue, trouble walking/talking and/or peak flow below_____: Take the medication below.

_____

If no improvement, call physician / 911

The above student is a pupil in your district and is under my medical care for asthma. He/She requires the medications listed in this asthma plan. Legislation allows the parent/guardian to authorize self-administration of medication so long as the pupil's physician certifies to the school district that the pupil has been instructed in and is capable of self-administration where indicated above for the treatment of asthma for this school year. In the event that the medication that I have prescribed is changed, or if the student is no longer capable of self-administration of the prescribed medication, I will notify the school district.

Physician Stamp/Name_____ Physician Phone: ( )_____ - _____

Physician Signature_____ Date_____

** Parent/Guardian: Please read and sign reverse side.**

Parent Request for Administration of Medication by School Nurse – Inhaler or Nebulizer

I request that the medication indicated on the reverse side be administered to my child. I acknowledge that the school district and its employees or agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and/or pharmacist with any question concerning the medication.

PARENT/GUARDIAN SIGNATURE_____

DATE_____STUDENT'S GRADE_____

Parent Consent for Self-Administration of Medication by Student – Inhaler Only

I am aware that legislation allows students to self-administer medication in the treatment of asthma as long as the physician certifies that the student has been instructed in and is capable of self-administering the prescribed medicine.

I acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and I agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the self-administration of medication by the pupil.

I authorize the student_____to self-administer the medications certified by the physician for self-administration that appear on the reverse side of this form for the treatment of asthma during the current school year.

PARENT/GUARDIAN PRINTED NAME_____

PARENT/GUARDIAN SIGNATURE_____

DATE_____ PHONE: ( )____-_____