Rev: 4/2009

Anchor Bay School District
Asthma Medical Care Plan

Place Child's Picture Here

Student Name____ Date _____________
Grade_________________Teacher____

Emergency Contact information (**<u>Please list in order to be called</u>**)

#1 Parent ____
Home Phone ______________________ Cell Phone _________________________
Work Phone_______________________

#2 Parent ____
Home Phone ______________________ Cell Phone __________________________
Work Phone ______________________

Alternate contacts if parents are unavailable. This should be someone familiar with your child's Asthma and would be able to advise school staff how to proceed with your child's care in the event that both parents are unavailable during the school day.

#3 Contact - Name ____
Relationship ____
Home Phone __________________________ Cell Phone ______________________________

#4 Contact – Name____
Relationship ____
Phone ________________________________ Cell Phone ______________________________

PARENTS PLEASE NOTE:

- Please check all expiration dates on all <u>medications</u> and <u>medical supplies.</u>
- **No expired medications or supplies will be used at school**.
- If difficulty breathing gets worse, the school will call 911 and then the Emergency contacts in the order listed above until someone is contacted.
- Please be sure to sign the Parent Signature areas of the Medical Care Plan and the Medication Administration forms.

Please have your child's Physician complete this <u>Medical Care Plan</u> and the <u>Medication Administration Request.</u> Please return to your child's school office ASAP.

If you have any questions about the Medical Care Plan or Medication Administration Forms, please contact your school office.

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. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if ____
____
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✓ Coughs constantly
   - ✓ 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
     - Stooped body posture
     - Struggling or gasping
   - ✓ Trouble walking or talking
   - ✓ Stops playing and can't start activity again
   - ✓ Lips or fingernails are grey or blue

If This Happens, Get Emergency Help Now!

• Emergency Asthma Medications

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

Daily Asthma Management Plan

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

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

Comments ____

• Control of School Environment

(List any environmental 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.			

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 that medication by him/herself.

☐ It is my professional opinion that ___________________should *not* carry his/her inhaled medication by him/herself.

Signature of Physician ____

Printed name of Physician: ____
Address: ____
City/Zip: ____
Phone: ____

Signature of Parent(s): ______________________________________ **Date:** __________

______________________________________ **Date:** __________