Anchor Bay School District
Asthma Medical Care Plan

Student Name______________________________________ Date ____________
Grade________________Teacher_______________________________________

Emergency Contact information (Please list in order to be called)
#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 medications and medical supplies.
➢ 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 Medical Care Plan and the Medication Administration Request. 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
       • Stopped 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     ☐ Strong odors or fumes     ☐ Other ____________________________
☐ Respiratory infections ☐ Chalk dust / dust 
☐ Change in temperature   ☐ Carpets in the room
☐ Animals       ☐ Pollens 
☐ Food ____________________________   ☐ Molds

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

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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: ____________