

School year _____

Student legal last name _____ First name _____ MI _____

Birth date _____ School _____ Grade _____ Other ID# _____

Transportation: Walker Self Transported Bus Rider Bus/Route Number _____

Parent/Guardian Information

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Physician and Hospital Information

Physician Name _____ Phone _____

Preferred Hospital _____ Phone _____

Medical Information

Current Medications (Rescue & Maint.) _____

Asthma History _____

Triggers _____

Special Precautions _____

Medication Orders

Medication Name _____ Dose _____ When _____

It is medically necessary for this student to carry an inhaler during school hours Yes No

Student may self-administer inhaler Yes No Student has demonstrated use to Licensed Health Care Professional Yes No

Physician's Signature _____ ****Original signature required! Please print and sign.****
(This notation will not print.) Date _____

Physician's name _____ Phone _____ Fax _____

Emergency Intervention

(Not all students will experience all symptoms during an asthma attack)

Moderate Symptoms	Immediate Response
Excessive coughing Wheezing Shortness of breath Chest tightness Nostrils flaring Shoulders hunched over Anxious or scared Peak flow to	Accompany student to health room (do not send alone) Give medication as prescribed by IHP Keep student sitting up and reassure student Encourage to relax and take deep slow breaths Encourage student to drink warm water Stay with student until improvement noted Contact School Nurse Contact parent/guardian if no improvement after 15-20 minutes

Severe Symptoms	Immediate Response
Lips or nail beds turning gray or blue (student with light complexion) Paling of lips or nail beds (students with dark complexions) Grunting Inability to speak in complete sentences without taking a breath Severe restlessness Decreasing or loss of consciousness	Call 911 Notify Parent/Guardian Notify School Nurse Notify School Principal Do not leave the student unattended

Classroom Accommodations - Modifications

Report concerns to parent/guardian for physician follow-up

Emergency Contacts

Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____

Parent/Guardian Signature _____ ****Original signature required! Please print and sign.****
(This notation will not print.) Date _____

School Nurse Signature _____ ****Original signature required! Please print and sign.****
(This notation will not print.) Date _____

Physician Signature _____ ****Original signature required! Please print and sign.****
(This notation will not print.) Date _____

A copy of this plan will be kept in the school office and copies will be given to:

- Para educator
 Transportation
 Teacher
 PE Teacher
 Student Services
 Health Room
 Secretary-Principal

Other _____

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING