Elko County School District Asthma Management Plan

Name:_____ DOB:_____ Grade/Teacher:_____

TO BE COMPLETED BY PARENT/GUARDIAN

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse. I request treatment be administered in accordance with my child's licensed healthcare provider's orders. I will notify the school if my child's health status changes or we change healthcare providers. I agree to prove all necessary equipment and supplies properly labeled.

***My child may carry/use his/her: Inhaled asthma medicine: __Yes __No Epi-Pen: __Yes __No**

Parent/Guardian signature:_____

Telephone number: (Home):_____ Work:_____ Cell:_____

TO BE COMPLETED BY STUDENT'S PHYSICIAN/HEALTHCARE PROVIDER

Provider Name:_____ Phone:_____ Fax:_____

PEAK FLOW: Child's predicted, or personal best peak flow:_____ Date:_____

Child's **Green** Zone:	**Yellow** Zone:	**Red** Zone:

MEDICATIONS:

Preventative (Controller) Medications:

Quick Relief Medications: (Check the appropriate quick relief med, circle device, list dose/frequency):

__Albuterol (Proventil, Ventolin) __Pirbuterol (Maxair) __Other:_____

Inhaler with: __spacer OR __nebulizer Dose/Frequency:_____

ALLERGIES/TRIGGERS FOR ASTHMA: __Exercise __Pollens __Cold Air __Animals

__Environmental Irritants __Respiratory illness __None known

__Other:_____

EXERCISE PRETREATMENT INSTRUCTIONS: (check all that apply)

__Give 2 puffs of quick relief inhaler 15 minutes prior to recess/physical education and/or:_____

__May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or_____

__Measure Peak Flow prior to recess/physical education; restrict aerobic activity when child's peak flow is below:_____

__Other:_____

ASTHMA EXACERBATION TREATMENT INSTRUCTIONS:

YELLOW ZONE: If child is coughing, wheezing or short of breath, and/or peak flow is in Yellow Zone:

__Give 2 puffs of quick relief inhaler with spacer (or nebulizer treatment). May be repeated in 10 minutes if doesn't recover to Green Zone, notify parents of exacerbation.

__Other:_____

RED ZONE: If child is in respiratory distress, and/or peak flow is in Red Zone:

__Call 911. Give 4 puffs quick relief inhaler (or nebulizer treatment), and call parent.

__Other:_____

*Nevada law permits students to carry and use inhaled medications and Epi-pen after demonstrating appropriate use of Inhalers and/or Epi-pen. Please check appropriate boxes below:

__This student has the knowledge and skill to carry and use: __**Inhaler medication** __**Epi-pen**

__This student is NOT able to carry and use by him/herself: __**Inhaler medication** __**Epi-pen**

__Please contact Healthcare Provider and parent if student is using quick relief medications more than 2 times a week (with exception to pre-exercise treatment).

__Other:_____

Healthcare Provider Signature:_____ Date:_____

TO BE COMPLETED BY SCHOOL NURSE

This student demonstrates knowledge and skill to carry and use:

Inhaled asthma medicine: __Yes __No Epi-Pen: __Yes __No __N/A _____

School Nurse Signature Date

Student Name: _____ Grade/Teacher: _____

EMERGENCY CONTACTS

Name/Relationship	Phone Numbers	

TO BE COMPLETED BY SCHOOL NURSE

TRAINED STAFF MEMBERS

(PRINT NAME/ SIGNATURE)

Print Name	Signature