Little Chute School District

Health Services

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Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus Student: Yes No**

Health Condition: Respiratory- Emergency Care for Diagnosis of:

_____ **Asthma -** Please Circle: Mild Moderate Severe

_____ **Other** _____

Emergency Plan: Emergency Action is Necessary when the student has symptoms such as: _____

_____

Steps to take during a breathing emergency: DO NOT LEAVE STUDENT UNATTENDED!

1. Calmly instruct students to take deep breaths.
2. Give medication as listed below. Students should respond to treatment in 15 to 20 minutes.
   - _____ Medication kept in school office
   - _____ Student carries her own inhaler at school.
   - _____ No medication kept at school.
3. Contact parents if: _____
4. Seek emergency medical help now if the student has any of the following:
   a. Coughs constantly
   b. No improvement 15 to 20 minutes after initial treatment with medication and a relative cannot be reached.
   c. Hard time breathing with:
      i. Chest and neck pulled in with breathing
      ii. Struggling or gasping
      iii. Nose flares open wide
      iv. Stooped body posture
      v. Breathing is hard and fast
      vi. Ribes showing with breath
   d. Can not walk or talk
   e. Stops playing and can't start activity again
   f. Lips or fingers are grey or blue
   g. Student has no inhaler available at school/activity

Emergency Medications:

Name:	**Amount:**	**When to Use:**

Parent/Emergency Contact Information:

Contact Order:	**Name:**	**Relationship to Student:**	**Phone:**
1			
2			
3			

***Note: Please update the health services team throughout the year of any changes in phone number and/or emergency contacts.**

Please Identify the things that may start a breathing emergency: (ex. Animals, change in temperature, etc.)_____

_____

Please list any environmental control measures, pre-medications and/or dietary restrictions that the student needs to prevent an emergency episode: _____

_____

Daily Medication Plan:

Name:	**Amount:**	**When to Use:**

FOR COMPLETION BY PHYSICIAN: Physician's Name: Phone:

Diagnosis:

Name of Medication:

Form:	**Dosage:**

Is the child knowledgeable about his or her medication: _____ Yes _____ No

Has the child demonstrated the proper technique in administering medication: _____ Yes _____ No

In your professional opinion should this child be allowed to carry and self administer his/her medications.
_____Yes _____No

Medicine is Administered Daily: _____ Yes _____ No	If yes, Time:

Medicine is administered when needed. Indications:

If needed, how soon can administration of medicine be repeated:	The medication can not be repeated more than:

Side Effects:

Physicians Signature:	Date:

For Completion by Parent: Is the child authorized to carry and self-administer inhaled medications: Yes_____ No_____

Medication Consent: I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary. If self-administration is allowed, or if no authorized staff member is available, I ask that my child be permitted self-medication as authorized by my physician and myself.
I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing you agree you have reviewed this health plan for your child and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parents Signature:	**Date:**

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Principal's Initials: _____