LITTLE CHUTE AREA SCHOOL DISTRICT
School Health Services
ASTHMA HEALTH PLAN

Student's Name: **DOB**:

The student named above has a medical history of ASTHMA. Asthma symptoms present as mild respiratory distress with evidence of cough, shortness of breath, wheezing, and chest tightness and discomfort. Sometimes, asthma symptoms may be precipitated by exercise, allergies, and viral infections. If this student presents with these symptoms or is requesting to use his/her inhaler, please do the following:

If student has an inhaler available:

1. Allow student to use his/her inhaler
2. Encourage the student to wait 1 minute between inhalations
3. Instruct the student to rest for a few minutes or until symptoms resolve
4. If symptoms resolve, student may return to class

If the student does not have access to an inhaler:

1. Contact parent immediately
2. Allow student to rest
3. If the student has great difficulty breathing despite treatments outlined above, or the student has white/gray skin color, uncontrolled coughing, audible wheezing or posturing: CALL 911, then contact a parent and school nurse.

Asthma is: ◯ mild ◯ moderate ◯ severe

Asthma is triggered by: **(check all that apply)**

☐ exercise ☐ respiratory infections
☐ stress or anxiety ☐ cold/humid weather
☐ allergies:
☐ other:

Medications given at home to treat asthma:

What are the student's symptoms? ☐ Coughing ☐ Shortness of breath ☐ Tightness in chest

☐ Wheezing ☐ Weakness ☐ Feeling anxious or nervous ☐ Itching in the throat

☐ Other

Will the student have an inhaler at school? ◯ NO ◯ YES **(requires LCASD medication paperwork on file)**

Where will he/she keep the rescue inhaler?

List any activity or weather restrictions:

( ) I have instructed in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that should NOT carry and use his/her inhaled medication by him/herself.

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EMERGENCY MEDICATIONS:

Medication Name:_____Strength:_____

Dose:_____Time Given:_____Route:_____

Side Effects:_____

_____

Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other nonemployee volunteers at the school or at school events and field trips. Please note that for the safety of the student, all staff members will be made aware of the student's asthma.