Fayette County School Health Services

ASTHMA HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

Severe Allergy 🛘 Yes 🖟 No

Studen	t:		Date of Bir	th: School Year:					
School	chool: Homeroom Teacher:			Grade/Team:					
EMER	GENCY CONTACTS								
·		Relationship	Phone Number	Email					
Asthm	na Healthcare Provider	•	Phone	Number:					
		<u> </u>	Thore Number						
EMERGENCY PLAN Emergency action is necessary when the student has symptoms such as,,,,									
, or has a peak flow reading of									
	TEPS TO TAKE DURING AN ASTHMA EPISODE: 1. Check peak flow.								
2.	Give emergency medications* below. Student should respond to treatment in 15-20 minutes.								
3.	Contact parent/guardian if								
4.	Re-check peak flow.								
5.	the following:								
	tion.								
Hard time breathing with chest and neck pulled in with breathing, stooped body posture									
	☐ Trouble walking and talking								
	☐ Stops playing and ca								
	Lips or fingernails are grey or blue								
•EMERGENCY ASTHMA MEDICATIONS*									
Medication Name		Dosage (amou	(nt) When to Use	Expiration Date					

DAILY ASTHMA MANA Check the triggers of an a		the student:				
Exercise		odors or fumes	☐ Food			
Respiratory infections	🛮 Chalk o		☐ Molds			
☐ Change in temperature		in the room	Other			
Animals	Pollens					
Control of School Environ		1				
List any environmental con				hat the student needs to		
prevent an asthma episode:						
Peak Flow Monitoring						
Student's Personal Best Pea	ak Flow Number:		Monitoring Times:			
	IA TIONG					
DAILY ASTHMA MEDIC Medication Name	ATIONS Dosage	When To Use	Expiration Date	Given at School		
Medication Name	(amount)	when 10 Use	Expiration Date	Given ai School		
	(amount)			□ YES □ NO		
				☐ YES ☐ NO		
				☐ YES ☐ NO		
				☐ YES ☐ NO		
				☐ YES ☐ NO		
PHYSICIAN'S AUTHORIZ	ZATION FOR INF	HALED MEDICAT	ΓΙΟΝS:			
☐ I have instructed the nan opinion this student shoul						
☐ It is my professional opin medication.	nion the named stu	dent should not car	ry and/or self medico	ate with the above		
\square Student should NOT part	icipate in outdoor d	activities if the polle	en count is High or V	Very High.		
▶ Physician's Signature ◀:			Date:			
PRINT Physician's Name:Telephone Number:						
I, this child's parent/guardian furnish to the School Health School. I understand that as of disclosure of certain medical ichild's medical needs may be sthe last day of the school year.	e), hereby authorize ervices Coordinator L's asthma and for th April 14, 2003, unde nformation is limited	the named Healthco and/or School Clinic ais information to be or the Health Insurand . However, I expressi	are Provider who has Staff any medical info shared with pertinent ce Portability and Acco ly authorize disclosure	attended to my child, to ormation and/or copies of school staff at my child's nuntability Act ("HIPAA") of information so that my		
► Parent/Guardian's Signa	ture ∢ :		Date:			

Implemented: August 2001

Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006; April 13, 2012; May 21, 2013