

# MIDDLEBOROUGH PUBLIC SCHOOLS

## ASTHMA CARE PLAN

<b>STUDENTS NAME:</b>	<b>SCHOOL:</b>
<b>BIRTH DATE:</b>	<b>ROOM #:</b> <b>BUS #:</b>
<b>PARENT NAME :</b>	<b>PARENT NAME :</b>
<b>(CELL)</b> <b>(W)</b>	<b>(CELL)</b> <b>(W)</b>

### ASTHMA TRIGGERS

<input type="checkbox"/> Respiratory viruses <input type="checkbox"/> Excessive play/exercise <input type="checkbox"/> Tobacco smoke <input type="checkbox"/> Strong odors/fumes <input type="checkbox"/> Changes in temperature	<input type="checkbox"/> Animals/dander _____ <input type="checkbox"/> Mold <input type="checkbox"/> Chalk/chalk dust <input type="checkbox"/> Dust mites <input type="checkbox"/> Poison oak	<input type="checkbox"/> Pollens <input type="checkbox"/> Stinging insects _____ <input type="checkbox"/> Poison ivy <input type="checkbox"/> Poison sumac <input type="checkbox"/> Others _____
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Does this student use a peak flow meter to monitor need for medication?     NO     YES     DOES NOT USE  
 Personal best reading: \_\_\_\_\_

**Medications for asthma: For students needing rescue medication, the medication is required to be at school in a safe and accessible location.**

Medication (home and school)	Dose and Route	Frequency	Side Effects

### RESCUE PROCEDURES

Circle Student Symptoms	Treatment	EMERGENCY: Call 911 if:
Excessive dry cough  Mild wheeze  Fast shallow breathing  Shortness of breath  Chest tightness  Mild chest retractions  Peak flow meter:  _____ % or less of _____	Give rescue medication: _____  Calm the student. Keep the student under observation until the parent arrives.  Allow the student to remain in school if symptoms improve or if peak flow meter reading/pulse oximetry is within safe range for this student.  Notify parents/principal immediately if determined 911 should be called.  <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">             School staff should accompany student to Emergency Room if parent/guardian/emergency contact unavailable.           </div>	Symptoms continue to worsen 15-20 minutes after initial treatment  Student continues to have difficulty breathing Chest/ neck pulled in when breathing Student is hunched over Struggles to breathe Coughs constantly  Difficulty walking/talking.  Student unable to resume activity.

**MPS ASTHMA CARE PLAN ADDITIONAL CONSIDERATIONS:**

**Field Trip Procedures – Rescue meds should accompany student during any off –site activities.**

- ♦ The student should remain with staff or parent/guardian during the entire field trip  Yes  No
- ♦ Staff members will follow Field Trip emergency protocol (911) and this health care plan (plan will accompany student).
- ♦ Other (specify) \_\_\_\_\_

**Self- Medication- for School Age/Youth**

YES, student can self-medicate. The school nurse has assessed the student and finds the student competent to use his/her medication safely. \_\_\_\_\_ has been instructed not to share medications and should \_\_\_\_\_ violate these restrictions the privilege of self-medicating will be revoked and his/her parents notified. The parent/guardian will provide a physician order for self medication.

**OR**

NO, After assessing the student, it is my professional opinion that \_\_\_\_\_ SHOULD NOT carry or self administer his/her medication.

**Bus –Transportation should be alerted to student’s condition.**

- This student carries rescue meds on the bus BUS # \_\_\_\_\_  Yes  No
- Rescue meds can be found in:  Backpack  Waistpack  On Person  Other \_\_\_\_\_
- Student will sit at front of the bus  Yes  No
- Other (specify) \_\_\_\_\_

**Parental Permission/Consent:**

**If the school nurse is in agreement with the student’s physician that the student is safe to carry his/her inhaler and self-medicate then the Parent/Guardian signature gives permission for the nurse/student to administer prescribed medicine and for the nurse to contact emergency medical services if necessary.**

**Student Statement of Understanding:**

**I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, the privilege of self-medication will be revoked and my parents notified.**

Type or Print Name of Student (if given permission to self-medicate and applicable per age of student)	Student Signature/DATE
Type or print name of Parent/Guardian	Parent Signature/DATE
Type or print School Nurse Name	School Nurse Signature/ DATE