# Asthma Health Care Plan
# USD 313
# Buhler, KS

**Parent Complete** **Please Print and Sign Below**

Student Name ________________________________________ DOB ______/ ______/ _____
Address ____________________________________________ Grade ___________________
Mother ______________________________ Father _________________________________
Home phone __________________________ _________________________________
Work phone ___________________________ _________________________________
Cell phone ____________________________ _________________________________
ER contact #1 (other than parent) Name ______________________ Phone _________________
ER contact #2 (other than parent) Name ______________________ Phone _________________
Known drug allergies ____________________________________________________________
Specific triggers/allergens ________________________________________________________
_______________________________________________________________________________

**Physician Complete** **Please Print and Sign Below**

Physician Name _______________________________________ Phone __________________
Specialist's Name ______________________________________ Phone __________________
Diagnosis _____________________________________________________________________
S/S ___________________________________________________________________________
Medications/treatments to be given at school _________________________________________
_______________________________________________________________________________
If student remains symptomatic, may repeat treatment in ________ minutes.
Other medications given at home ___________________________________________________
_______________________________________________________________________________

**Seek emergency treatment if the student has any of the following:**

- Severe coughing, wheezing, shortness of breath or tightness in chest.
- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Trouble walking or talking
- Lips or fingernails are grey or blue
- Peak flow of ____________
- Retractions - skin sucks in around ribs and/or neck. Nostrils flare out
- Shoulders hunched over

Parent signature ________________________________________ Date __________________
(I give permission for USD 313 nurses to exchange health information per phone or writing with my child's physician.)
Physician's signature _____________________________________ Date __________________
School nurse ___________________________________________ Date __________________

# Permission for Self-Administration of Inhaler

On any occasion that students must use an inhaler at school, this form must be completed and signed in advance by the student's parent or guardian, student **and the physician**. It must be on file in the school office for an inhaler to be carried or self-administered. All inhalers must be furnished by the parent/guardian.

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## Request to Self-Administer Inhaler at School

Student's Name ____________________________________________________________

Medication ________________________________________________________________

Reason for Medication _______________________________________________________

Dose ___________________________ Times(s) to be given ______________________________

Dates to be given __________________________________________________________

I hereby request that _________________________________ be allowed to carry and self-administer his/her inhaler as prescribed by our medical doctor. I understand that it is my responsibility to furnish the medication as noted above. **Please request that the pharmacist place an appropriate label on the inhaler so that the inhaler is easily identified.**

I realize the privilege of self-administration may be revoked at any time if my student is not handling the medication safely. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

________________________________________ ____/____/____

signature of parent/guardian date

Students Responsibility:

1. At all times, I will keep the inhaler in my possession.
2. I will use the inhaler only as prescribed by my doctor.
3. I will not share this inhaler with others.

I realize I can lose this privilege if I mishandle my inhaler.

________________________________________ ____/____/____

student's signature date

________________________________________ ____/____/____

Physician's signature date