04/2019

GREEN CHARTER SCHOOL

Physician and Parent School Asthma Management Plan

Student:	DOB:	Phone:
Physician:	Physician Phone:	

RESCUE: With Breathing Difficulties Give Rescue Medicine: ______________________________

MEDICATION:	**DOSE:**

Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved. If student is still experiencing breathing difficulties after 20 minutes:

ITIS /ITIS NOT okay to repeat rescue treatment. Observe student for twenty minutes between treatments or until breathing difficulties are relieved. It is okay to repeat rescue treatment a total of_______________times to relieve breathing difficulties.

1. Puffs should be administered individually with 10-second breath hold, wait at least ______ seconds between puffs.
2. If students breathing difficulties are not relieved after the above maximal treatment, parents should be called to come pick-up child from school and notified of need for call to physician for urgent medical attention.

If more than one rescue treatment is ever required to relieve breathing difficulties or student *requires rescue treatment more than two times in one week, the parents should be notified of need to schedule physician office visit for poorly controlled*

If student is experiencing extreme shortness of breath or lips and fingernail beds are blue, Emergency Medical Services (EMS) should be called, and rescue albuterol treatments given until EMS arrives.

C PL . ***During Asthma Flare-ups scheduled rescue treatments are needed:***

For one week following an ER ***or physician office visit for an asthma flare-up or notification of sickness by parent: Administer*** _________________puffs/ of_______________________*every four hours and before PE or other strenuous activities. If student requires rescue treatment before four-hour treatment interval parents should be called to pick-up student and notified of need for physician visit.*

- It is the responsibility of student's parent/guardian to notify the school nurse of student's asthma flare-up or chest cold and the need for scheduled treatments
- After 48 hours on the above sick plan treatment, if the asthma symptoms do not improve or get worse, parents should be contacted with concerns. Some sick plans may extend in excess of one week
- If after one week on sick plan all asthma symptoms do not disappear parent should be notified of need to schedule a physician office visit for poorly controlled asthma.
- All ER visits for asthma flare-up should be followed by a Physician Office visit within 3 days. Unless contrary to ER physician's judgment, it is okay for child to attend school until follow-up visit

DAILY ASTHMA CONTROL PRESCRIBED FOR HOME

MEDICATION	DOSE	FREQUENCY

- Known Allergies and Asthma Triggers include: ______________________________
- All asthmatics should avoid exposures to airway irritants like smoke, perfume, dust, air fragrances and high levels of ozone.

HEALTH ROOM GUIDELINES

□ Student may carry the inhaler at school □Student also needs inhaler available for rescue in the Health Room	**□Student should have inhaler in the Health Room for administration by nurse or designated district employee**	**□Student needs treatment with rescue inhaler prior to: □Physical Education □ Recess Doses should be 4 hours apart**	**□ Student does not need treatment with rescue inhaler routinely except during asthma flare-up**

SPACER RECOMMENDED: **□ Yes □ Not required**

I AGREE WITH SCHOOL AND HOME ASTHMA MANAGEMENT PLAN. My child has my permission to use inhaler at school as described in plan. I agree to communication of changes in my child/guardian's asthma condition and management plans between my child/guardian's school, hospital and physicians. I, as the person responsible for my child/guardian's medical care, will be included/informed of communication regarding my child's medical care.

Guardian's Signature:____Date: ___________________________

I have seen this child, authorize inhaler use at school in health room according to plan, and agree with plans for management of student's asthma at home and school.

Physician's Signature:____Date: ___________________________