NODAWAY-HOLT SCHOOL DISTRICT – ASTHMA MEDICAL ORDERS / CARE PLAN – School year: 2021-2022

STUDENT'S NAME:		Date of Birth:
School:	Grade:	
Doctor Name:	Phone#:	Fax#:
Transportation to/from school: ☐ Walk	☐ Car	☐ Bus
Medications taken at home:		

LICENSED HEALTH PROFESSIONAL – DAILY ASTHMA MANAGEMENT PLAN
(Must be completed by licensed health professional)

Identify asthma triggers: *(Check each that applies to this student)*

☐ Exercise ☐ Pollens ☐ Molds ☐ Respiratory Infections ☐ Change in Temperature/Season

☐ Other:_____

***Warning signs of an Asthma Episode:_____

SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement 15-20 minutes after initial treatment with medication and a parent/emergency contact cannot be reach, or if condition worsens during this period
- Difficulty walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue
- Difficulty breathing with:
  - **Chest and neck pulled in with breathing**
  - **Child is hunched over**
  - **Child is struggling to breathe**

Inhaler to be kept:

☐In Office

☐In Backpack

☐On Person

EMERGENCY ASTHMA MEDICATION

Medication	Amount	When to Use	Route
1.			
Any Side Effects:			

Time interval for repeating dosage:

- **If symptoms not relieved after initial dose:**
- **If symptoms reoccur before next dose is due:**

It is my professional opinion that this student (circle one) **SHOULD/SHOULD NOT** carry and use his/her rescue medication/s/ by himself/herself at school. I have instructed this student in the proper way to use these medications.

***He/she has successfully demonstrated the ability to self-administer. ☐Yes ☐No ☐ Unable

Physician's Signature	Date	Phone#
Printed Name		

PARENT/GUARDIAN SECTION

Parent Name:	Parent Name:	Emergency Contact:
Home #:	Home #:	Home #:
Work #:	Work #:	Work #:
Cell #:	Cell #:	Cell #:

Parent's signature gives permission for the administration of the above ordered medication at school by authorized personnel, and gives permission for the school designee to communicate freely with the licensed health care provider.

_____

Parent/Guardian Signature Required

Permission to carry and self-administer inhaler: **Yes / No
(Circle one)