HERNANDO COUNTY SCHOOL DISTRICT

ASTHMA CARE PLAN

School Year ___________ - _____________

Student Name: ____________________________ Date of Birth _________ Student ID# ________________

School Name _____________________________ Grade _____ Teacher _________________ Bus _______

Contact Information

Parent/Guardian # 1 ______________________ Phone # Home _________ Work _________ Cell_________

Parent/Guardian # 2 ______________________ Phone # Home _________ Work _________ Cell_________

Other emergency contact ______________________________ Relationship _________ Phone # _________

Other emergency contact ______________________________ Relationship _________ Phone # _________

Asthma Health Care Provider ______________________________________ Phone # __________________

Primary Physician ____ Phone # __________________

Hospital Choice: **<u>Please check</u>**

❏ Oak Hill Hospital ❏ Brooksville Regional Hospital ❏ Spring Hill Regional Hospital

Emergency Notification: **<u>Check the Symptoms</u>** usually seen for this student (If parents/guardian can't be located, 911 will be called for student in acute respiratory distress)

❏ Multiple Requests for Rescue Inhaler/Nebulizer

❏ Chest Tightness

❏ Worsening Wheeze

❏ Dusky Color

❏ Exhaustion

❏ Excessive Coughing

❏ Unable to Speak in Complete Sentences

❏ Shortness of Breath

❏ Chest Pain

❏ Hunched Shoulders

❏ Lips/Nails Blue in Color

❏ Straining Neck Muscles

❏ Nasal Flaring (widening)

Other ____

DOES STUDENT HAVE CONTRACT TO CARRY OWN INHALER? **❏ YES ❏ NO**

DATE OF LAST ASTHMA ATTACK: ____

DATE OF LAST EMERGENCY ROOM VISIT FOR ASTHMA _________________________________

DATE OF LAST HOSPITALIZATION FOR ASTHMA ______________________________________

(Pease complete - page 2)

DISTRIBUTION
White : School Clinic
Yellow : Parent

Student Name: ____________________________

ASTHMA MEDICATIONS AT SCHOOL/HOME

Drug Name ____________________________ Dose ______________ Time Given __________

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Drug Name ____________________________ Dose ______________ Time Given __________

For any medications in school, a Medication Authorization Form must be completed

NEBULIZER TREATMENT: Drug ____

Dose ______________________ Frequency ______________________

RESCUE INHALER TREATMENT: Drug ____

Dose ______________________ Frequency ______________________

ASTHMA TRIGGERS: **Please check all that apply**

❏ Dust ❏ Mold ❏ Bugs ❏ Sprays ❏ Cats/Dogs

❏ Exercise ❏ Weather changes ❏ Smoke ❏ Household Products

Other ____

Does student use a Peak Flow Meter? ❏ YES ❏ No

If Yes, Normal/Best Range ____________________ **or** ❏ Red ❏ Yellow ❏ Green

Has student attended an Asthma Education Program such as Open Airway? (Sponsored by the American Lung Association) ❏ Yes ❏ No Date of Education Program ______________________

List other emergency procedures for student experiencing Asthma signs/symptoms

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Parent/Guardian Signature/Date ____

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Public Health Nurse Signature/Review Date