**ASTHMA TREATMENT PLAN**

**\*Please note that this EMERGENCY TREATMENT PLAN will be shared with South Hackensack Memorial School staff members that are DIRECTLY involved in your child’s daily activities. This sharing of information is to ensure the safety and health of your child.**

|  |  |  |
| --- | --- | --- |
| **Students**  **Name:** | **Students**  **Grade:** | **Students**  **Teacher:** |

**What are the triggers that cause my child to have an ASTHMATIC EPISODE?** Please check all that apply.

Exercise \_\_\_\_ Cold Symptoms \_\_\_\_ Odors \_\_\_\_

Latex \_\_\_\_ Changes in Temperature \_\_\_\_ Dust \_\_\_\_

Chalk Dust \_\_\_\_ Animal/Animal Hair \_\_\_\_ Seasonal \_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication For Asthma:**

* **Takes daily at home before school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Takes during school if needed:**
* Inhaler (puffer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nebulizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **My child has my permission to carry AND self-administer an inhaler (puffer) treatment if needed.**
* Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **I grant the name physician below, permission to speak with the school nurse for immediate medical needs regarding my child. Circle YES or NO**
* Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **My child requires being kept indoors during extreme weather. Please keep indoors if temperature is lower than \_\_\_\_\_\_\_ degrees or higher than \_\_\_\_\_\_\_\_\_\_.**
* **To be signed by health care office personnel once proper demonstration inhaler (puffer) is seen.**
* School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* School Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY SPECIALTY PHYSICIAN OR PEDIATRICIAN**

Please list all asthmatic medications below with directions for administration. If you need more space, please attach a letterhead to this plan of care.

* Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN STAMP HERE**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**