PULASKI COMMUNITY SCHOOL DISTRICT

STUDENT ASTHMA MANAGEMENT PLAN

Student Picture

Student's Name:	DOB:	Date:
School Attending:	Grade:	Bus Student: Yes No

Healthcare Provider treating student for Asthma_____**Phone**_____

Preferred Hospital_____

List your child's common asthma symptoms_____

GREEN ZONE: ALL CLEAR

Symptoms	***Actions***
1. Breathing is easy. No asthma symptoms with activity or rest. 2. Peak Flow Range: ____ to ____ (80-100% personal best) *if applicable.*	☐ Pre-medicate if needed 10-20 minutes before physical activity, or other _____. ☐ Pre-exercise medication listed in #1 below.

YELLOW ZONE: CAUTION

Symptoms	***Actions***
1. Cough or wheeze. Chest is tight. Short of breath. 2. Peak Flow Range: ____ to ____ (50-80% personal best) *if applicable.*	☐ Medicate with rescue inhaler. Listed below. ☐ May recheck peak flow in 15-20 minutes. ☐ Student should respond to treatment in 15-20 minutes and return to green zone. ☐ Contact parent if not responding to treatment.

RED ZONE: EMERGENCY PLAN

Symptoms	***Actions***
1. Chest and neck pulled in with breathing. 2. Stooped body posture. 3. Struggling or gasping. 4. Difficulty walking or talking due to shortness of breath. 5. Lips or fingernails blue or grey color. 6. Peak flow below ____ (50% personal best) *if applicable.*	☐ Medicate with rescue inhaler. Listed below. ☐ Recheck peak flow in 15-20 minutes. ☐ If student does not respond to treatment, repeat treatment. ☐ Recheck peak flow in 15-20 minutes. ☐ Call 911 and parent if student not responding to treatment, or if condition quickly worsens.

Emergency Medications:

	Name	Amount	When to use
1.			
2.			

Parent / Emergency Contact information:

	Name	Relationship to Student	Daytime Phone
1.			
2.			
3.			

Over

Daily Management Plan cont.:

Identify your child's asthma triggers. (Check all that apply.)

- □ Exercise
- □ Respiratory infections
- □ Changes in temperature
- □ Animals
- □ Food _____
- □ Strong odors or fumes
- □ Chalk dust / dust
- □ Carpets in the room
- □ Pollens
- □ Molds
- □ Other _____

_____

Control of School Environment:

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an emergency episode:

_____

Peak Flow Monitoring: Student has a peak flow meter: _____ Yes _____ No Personal Best Peak Flow number: _____

Daily Medication Plan:

Name	Amount	When to use
1.		
2.		
3.		

FOR COMPLETION BY PHYSICIAN: **Physician's Name:** **Phone:**

Diagnosis:

Name of Medicine:

Form:	Dosage:

Is the child knowledgeable about his or her medication: ___Yes ___No

Has the child demonstrated the proper technique in administering medication: ___Yes ___No

Medicine is administered daily. ___Yes ___No	If yes, time:

Medicine is administered when needed. Indications:

If needed, how soon can administration of medicine be repeated?	The medication cannot be repeated more than:

Side effects:

( ) I have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that _____ should not carry and use his/her inhaled medication by him/herself.

Physician's Signature:	**Date:**

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer inhaled medications: Yes _____ No _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Pulaski Community School District, and the PCSD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus driver and office staff.

Parent's Signature	**Date:**