GRIFFIN-SPALDING COUNTY SCHOOLS

ASTHMA HEALTH CARE PLANS

Student: _____ Birth Date: _____ School Year: _____

School: _____ Homeroom Teacher: _____ Grade/Team: _____

Parent/Guardian's Names: _____

Home Phone: _____ Other: _____

Father's Work Phone: _____ Mother's Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Other: _____

Physician's Name: _____ Phone Number: _____

Physician student sees for Asthma: _____ Phone Number: _____

DAILY ASTHMA MANAGEMENT PLAN

Check the things that start an asthma episode for the student:

___ Exercise	___ Strong odors/fumes	___ Respiratory Infections
___ Animals	___ Change in Temperature	___ Foods
___ Chalk Dust	___ Molds	___ Other
___ Carpets	___ Pollens	

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

_____

_____

Student's Personal Best Peak Flow Number: _____ Monitoring Times: _____

Daily Medication Plan:

EMERGENCY PLAN:

Emergency action is necessary when the student has symptoms such as :

_____

_____

Or has a peak flow reading of: _____

Steps to take during an asthma episode:

1. Give Emergency Asthma Medications:

2. Have the student return to classroom if: _____
3. Contact the parent/guardian if: _____
4. Call Emergency Medical Services (911) if the student has any of the following:
    - No improvement 15-20 minutes after initial treatment.
    - Peak Flow of _____
    - Hard time breathing with
        - Chest and neck pulled in with breathing
        - Child is hunched over
        - Child is struggling to breath
    - Trouble walking or talking
    - Stops playing and can't start activity again
    - Lips or fingernails are gray or blue

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

☐ It is my professional opinion that (student) _____ should not carry and use medication him/herself.

Physicians Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I, (parent/guardian) _____, hereby authorize (Healthcare Provider) _____, who has attend to my child _____, to furnish to the (School Health Services Staff) any medical information and/or copies of records pertaining to my child's asthma and for this information to be shared with pertinent school staff. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA) disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Griffin-Spalding County Schools. This authorization expires as of the last day of school 20___.

Parent/Guardian's Signature: _____ Date: _____