

Loudoun County Public Schools Physician Order/ Care Plan for Asthma

STUDENT'S NAME: _____
School: _____ **Grade:** _____ **Date of Birth:** _____
Homeroom Teacher: _____ **Room#:** _____
Gender: Male: _____ Female: _____ **Transportation:** Walker _____ Car _____ Bus#: _____
Physical Education Days and Time or Period (to be completed by school): _____

PHYSICIAN SECTION *(Must be completed by Physician)* DAILY ASTHMA MANAGEMENT PLAN

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

Exercise _____	Pollens _____	Personal best peak flow _____
Respiratory infections _____	Molds _____	
Change in temperature _____	Other _____	

Routine medication to be given at school. If more than one medication is to be given at same time, list in order to be given.

Medication	Amount	When to use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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

- | | |
|---|---|
| <ul style="list-style-type: none"> ✦ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached, or if condition worsens during this period. ✦ Peak flow less than _____ ✦ Difficulty breathing with: <ul style="list-style-type: none"> • Chest and neck pulled in with breathing • Child is hunched over • Child is struggling to breathe | <ul style="list-style-type: none"> ✦ Difficulty walking or talking ✦ Stops playing and can't start activity again ✦ Lips or fingernails are gray or blue |
|---|---|

EMERGENCY ASTHMA MEDICATIONS

Medication	Amount	When to Use	Route
1. _____	_____	_____	_____
2. _____	_____	_____	_____

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 **SHOULD/SHOULD NOT** carry and use his/her inhaled medication by him/herself at school. I have instructed this student in the proper way to use these medications.

Physician's Signature	Date	Telephone Number
Physician's Printed Name		Fax Number

PARENT/GUARDIAN SECTION

After completing section below, see other side if you child has your physician's permission to carry an inhaler

Emergency Information: Parent/Guardian names: _____
 Telephone Number(s) Mother _____ Father _____ Emergency Contact with Phone# _____
 Home _____ ① _____
 Work _____ ② _____
 E-mail or Fax _____

Parent's signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician if necessary. _____

Parent/Guardian Signature Required Date

Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Physician Order/Care Plan for Asthma.)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new Physician Order/Care Plan for Asthma and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic assistant.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering, I will report to the school nurse or another appropriate adult if the nurse is not available or present.

Student's Signature Required

Date