RETURN TO SCHOOL NURSE

Bus# _____
Car Rider YES/NO

SURRY COUNTY SCHOOLS SCHOOL HEALTH PROGRAM

Asthma Medical Management Plan

School Year_____

Name of Student _____Date of Birth_____

School _____Grade/Teacher_____

Parent/Guardian _____Phone _____

_____Phone _____

Physician _____Phone _____Hospital_____

1. How often does the child have an asthma attack? _____
2. Medications At Home_____

   Medications at School: _____Location: _____
3. Side effects from these medications:_____
4. Activities/exercise restrictions:_____

Identify the things that start an asthma episode (known as triggers.) Check each that applies to your child.

☐ Exercise	☐ Smoke, strong odors or spray
☐ Mold	☐ Colds/Respiratory infections
☐ Chalk dust/dust	☐ Carpet
☐ Pollen	☐ Change in temperature
☐ Animals	☐ Dust mites
☐ Tobacco smoke	☐ Cockroaches
☐ Food	☐ Other

The following are signs and symptoms that need immediate attention:

Coughing	Pale
Shortness of breath	Anxious face
Wheezing	Bluish nailbeds and lips
Whistling sounds	Perspiring
Gasping voice	Flaring of nostrils

Interventions:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by health care provider.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficulty or if medication is not effective.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to _____Hospital.
8. Additional instructions:_____

Addendum: The student's parent or guardian must provide to the school backup asthma medication that school personnel are to keep in a location to which the student has immediate access in the event of an emergency.

Student Responsibilities if Authorized to Self-Administer Medication

1. I will keep my medication / equipment with me at all times.
2. I agree to use my equipment and take my medication according to my Medical Management Plan.
3. I will notify my teacher or someone in the office if I am having more difficulty than usual with my health condition.
4. I will not allow any other person to use my equipment or take my medication.
5. I understand that the school will not be responsible for my equipment or medication. The condition and accuracy of it as well as the frequency of use is my responsibility.
6. It is my (and my parents) responsibility to notify the school of changes in my health status or in the use of my equipment or medication.

Student Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

Health Care Provider Signature _____ Date _____

(Health Care Provider Signature is not required if medication order is on file at the school)

Revised: 11/19/2019