HERNANDO COUNTY SCHOOL DISTRICT

ASTHMA CARE PLAN

School Year _____ - _____

Student Name: _____ Date of Birth _____ Student ID# _____

School Name _____ Grade _____ Teacher _____ Bus _____

Contact Information

Parent/Guardian # 1 _____ Phone # Home _____ Work _____ Cell_____

Parent/Guardian # 2 _____ Phone # Home _____ Work _____ Cell_____

Other emergency contact _____ Relationship _____ Phone # _____

Other emergency contact _____ Relationship _____ Phone # _____

Asthma Health Care Provider _____ Phone # _____

Primary Physician _____ Phone # _____

Hospital Choice: Please check

❑ Oak Hill Hospital ❑ Brooksville Regional Hospital ❑ Spring Hill Regional Hospital

Emergency Notification: Check the Symptoms usually seen for this student (If parents/guardian can't be located, 911 will be called for student in acute respiratory distress)

❑ Multiple Requests for Rescue Inhaler/Nebulizer
❑ Chest Tightness
❑ Worsening Wheeze
❑ Dusky Color
❑ Exhaustion
❑ Excessive Coughing
❑ Unable to Speak in Complete Sentences
❑ Shortness of Breath
❑ Chest Pain
❑ Hunched Shoulders
❑ Lips/Nails Blue in Color
❑ Straining Neck Muscles
❑ Nasal Flaring (widening)

Other _____

DOES STUDENT HAVE CONTRACT TO CARRY OWN INHALER? ❑ YES ❑ NO

DATE OF LAST ASTHMA ATTACK: _____

DATE OF LAST EMERGENCY ROOM VISIT FOR ASTHMA _____

DATE OF LAST HOSPITALIZATION FOR ASTHMA _____

(Pease complete - page 2)

DISTRIBUTION
White : School Clinic
Yellow : Parent

Student Name: _____

ASTHMA MEDICATIONS AT SCHOOL/HOME

Drug Name _____ Dose _____ Time Given _____

Drug Name _____ Dose _____ Time Given _____

Drug Name _____ Dose _____ Time Given _____

For any medications in school, a Medication Authorization Form must be completed

NEBULIZER TREATMENT: Drug _____

Dose _____ Frequency _____

RESCUE INHALER TREATMENT: Drug _____

Dose _____ Frequency _____

ASTHMA TRIGGERS: Please check all that apply

❑ Dust ❑ Mold ❑ Bugs ❑ Sprays ❑ Cats/Dogs

❑ Exercise ❑ Weather changes ❑ Smoke ❑ Household Products

Other _____

Does student use a Peak Flow Meter? ❑ YES ❑ No

If Yes, Normal/Best Range _____ **or** ❑ Red ❑ Yellow ❑ Green

Has student attended an Asthma Education Program such as Open Airway? (Sponsored by the American Lung Association) ❑ Yes ❑ No Date of Education Program _____

List other emergency procedures for student experiencing Asthma signs/symptoms

_____

_____

_____

Parent/Guardian Signature/Date _____

_____

Public Health Nurse Signature/Review Date