

**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)

- |                                                                         |                                                   |
|-------------------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Multiple Requests for Rescue Inhaler/Nebulizer | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Chest Tightness                                | <input type="checkbox"/> Chest Pain               |
| <input type="checkbox"/> Worsening Wheeze                               | <input type="checkbox"/> Hunched Shoulders        |
| <input type="checkbox"/> Dusky Color                                    | <input type="checkbox"/> Lips/Nails Blue in Color |
| <input type="checkbox"/> Exhaustion                                     | <input type="checkbox"/> Straining Neck Muscles   |
| <input type="checkbox"/> Excessive Coughing                             | <input type="checkbox"/> Nasal Flaring (widening) |
| <input type="checkbox"/> Unable to Speak in Complete Sentences          |                                                   |

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 \_\_\_\_\_

(Please complete - page 2)

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 \_\_\_\_\_