BUTLER ACADEMY

Physician & Parent School Asthma/Medication Management Plan

School Year: ________________

Student:	DOB:	Phone:
Physician Name:	Physician Phone:	

***RESCUE**: With Breathing Difficulties Give Rescue Medicine:*

Medication/Dose:_______________________________________

Mediation/Dose:____

Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved. If student is still experiencing breathing difficulties after 20 minutes:

It is / It is NOT **(Please Circle One)** *okay to repeat rescue treatment. Observe student for 20 minutes between treatments or until breathing difficulties are relieved.*

1. Puffs should be administered individually with a 10-second breath hold, wait at least 0 seconds between puffs.
2. If student's breathing difficulties are not relieved after the above maximum treatment, parent will be called to come pick-up child from school and notified of need for call to physician for urgent medical attention.

Daily Asthma Control Prescribed for Home Use

MEDICATION	DOSE	FREQUENCY

- Known Allergies and Asthma Triggers include: ____
  ____
- All asthmatics should avoid exposures to airway irritants like smoke, perfume, dust, air fragrances and high levels of ozone.

Physician Order: Please check all that apply.			
☐ Student may carry the inhaler at school ☐ Student also needs inhaler available for rescue in the Health Room	☐ Student should have inhaler in the Health Room for administration by nurse or designated district employee	☐ Student needs treatment with rescue inhaler prior to: ☐ Physical Education ☐ Recess ☐ Doses should be ______hours apart	☐ Student does not need treatment with rescue inhaler routinely except during asthma flare-up

SPACER RECOMMENDED: ☐ **Yes** ☐ **Not required**

I AGREE WITH SCHOOL AND HOME ASTHMA MANAGEMENT PLAN. My child has my permission to use an inhaler at school as described in the plan. I agree with communication of changes in my child/guardian's asthma condition and management plans between my child/guardian's school, hospital and physicians. I, as the person responsible for my child/guardian's medical care, will be included/informed of communication regarding my child's medical care.

Legal Guardian's Signature: ____ **Date:**______________

I have seen this child, authorize inhaler use at school in health room according to plan, and agree with plans for management of student's asthma at home and school.

Physician's Signature: ____ **Date:**______________