FHUSD #98
ASTHMATIC MANAGEMENT PLAN

This plan should be completed by the student's personal Physician or Licensed Healthcare Provider and parent/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the FHUSD Registered Nurse, Health Aides, and other authorized personnel.

☐ McDowell Mtn. 480-664-5201 ☐ Four Peaks 480-664-5102 ☐ Middle School 480-664-5402 ☐ High School 480-664-5501

Parent/Guardian must complete pages 1 and 2 only. The Physician or Licensed Healthcare Provider must complete the remainder of the FHUSD Asthmatic Management Plan.

Asthmatic Care Plan For:_____
(Student's Name)

Effective Date: _____ Grade: _____ Homeroom Teacher:_____
(See attached Schedule for F.H. Middle and High School students)

Birth Date: _____/_____/_____

Date of Diagnosis: ____/____/____

(Apply student photo above)

Emergency Contact Information

Parent/Guardian #1: _____ Home Phone: (____) _____

Work Phone: (____) _____ Ext# _____ Cell Phone: (____) _____

Address:_____

Parent/Guardian #2: _____ Home Phone: (____) _____

Work Phone: (____) _____ Ext# _____ Cell Phone: (____) _____

Address:_____

Student's Physician/Healthcare Provider: _____

Address:_____

Telephone: (____) _____ Emergency Telephone or Pager: (____) _____

Other Emergency Contact: _____ Home Phone: (____) _____

Address: _____Cell Phone: (____)_____

Relationship to student: _____ Work Phone: (____) _____Ext#_____

Notify parent/guardian or emergency contact in the following situations:_____

_____

Parent/Guardian please read and sign the Consent for Care on next page of this form.

FHUSD #98
Asthmatic Management Plan

Asthmatic Care Plan for_____
(Student's name)

When my child is nearing an asthma episode, I notice the following signs or symptoms:

□Runny/ Stuffy nose □Odd feeling in chest □Itchy Throat □Itchy Chest □Tummy Ache □Feeling weak □Headache □Dry Mouth □Getting upset □Nervous □Sad □Sneezing □Coughing □Watery eyes □Fatigue □Circles /darkening under eyes □other_____

My child's asthma triggers are:

□ Animal with fur □Dust □Cigarette smoke □Strong smells □Cold air □Humid air □ Colds □Sinus Infection □Exercise (Running, Sports) □Aerosols (Hair Spray, Perfume) □ Emotions (Sad, Happy) □Cockroaches □Mold

□*Foods* _____

□*Other*_____

Middle School and High School students ONLY (Kindergarten to 5th grade to be individually evaluated with District RN)

This student does carry a rescue inhaler with him/her during school □Yes □ No

(*Requires Form MA-3 Student Self Administration of Medication form - signed by parent -on file in health office)*

Parent/guardians - All medications and supplies prescribed by physician/ licensed healthcare provider are to be provided by parent/guardian to your student's school health office. Medications must be in original prescription labeled packaging, with current expiration dates. Expired medications will not be administered.

Parent / Guardian Consent for Care (to be completed by Parent/Guardian)

I / we give permission to the FHUSD Registered Nurse, Health Aide or designated staff members of
□McDowell Mountain Elementary School □ Four Peaks Elementary School
□Fountain Hills Middle School □Fountain Hills High School
to perform and carry out the asthmatic care task as outlined by _____'s
(Physician/Licensed health care Provider)

Asthmatic Medical Management Plan, I also consent to the release of the information contained in this Asthmatic Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

I understand it is the responsibility of the Parent/guardian to inform both the physician or licensed healthcare provider and the school of any changes in the student's health status. I / we give permission for release of information to/from the FHUSD to/from the physician/licensed health care provider for the school year 20___- 20____.
I have read and received a copy of the FHUSD Asthmatic Management Policy and Procedure.

_____ _____

Parent/Guardian #1 Date Parent/Guardian #2 Date

FHUSD #98
Asthmatic Management Plan

Asthmatic Care Plan For _____

(Students Name)

Health Care Provider's Plan of Care

(completed by Licensed Healthcare Provider)

Please write legibly to ensure quality care for our student.

Student □**will not** use a peak flow meter at school (fill out this page) □ **will** use a peak flow (fill out page 4 of this form**).**

Inhaler Usage:

Medication: _____ □ 2 puffs □ 4 puffs every _____hours, □PRN □Daily at or before: _____.

□May repeat □2 puffs □4 puffs in_____ minutes

OR □May repeat with parent /guardian authorization, □2 puffs□ 4 puffs in _____minutes x1

If not effective notify parent/ guardian to immediately pick-up student from school.

OR□ Go to SVN Plan below

Student □needs □does not need instruction on inhaler usage.

Middle School and High School students ONLY (Kindergarten to 5th grade to be evaluated individually with District RN)

This student does carry a rescue inhaler with him/her during school □Yes □ No

(*Requires Form MA-3 Student Self Administration of Medication form - signed by parent -on file in health office*)

SVN (Small Volume Nebulizer)

Medication: _____; _____ml in _____ml of saline, every _____hours.

□May repeat in _____minutes with □ same dosage *OR* □_____ml of _____/_____ml of saline.

If not effective notify parent/ guardian for immediate pick-up.

OR

□May repeat x1 with parent/ guardian authorization, in _____minutes □ same dosage *OR* □_____ml of medication / _____ml of saline. **If not effective notify parent/ guardian for immediate pick-up.**

Supply List for student use at school:

□**Inhaler (Must be original prescription packaging)** □**Spacer** □**Peak Flow Meter**

□**Inhalation medication for small volume nebulizer (SVN)** (**Must be original prescription packaging) and saline**

□ **SVN mask or mouth piece, aerosol chamber and tubing** □**Inhaler for field trip use (SVN's can not be taken on field trips)**

Signature

_____ _____

Student's Physician / Licensed Health Care Provider (LHP) Date

_____ Phone Number ____-____-_____

Printed Name of Physician / LHP

(FHUSD Form MA-5)

FHUSD #98
Asthmatic Management Plan

Asthmatic Care Plan

for_____

(Student's name)

Health Care Provider's Plan of Care (*completed by Licensed Healthcare Provider*)

Please write legibly to ensure quality care for our student.

Name of Physician or
Licensed Healthcare Provider (LHP) _____
Phone Number _____-_____-_____
Signature of LHP _____ Date _____

Green Zone

Student's Personal best peak flow meter reading is _____ **or**
Student's predicted flow meter reading is_____ > 80% of best Predicted Peak Flow_____ to_____
Inhaler use before exercise □ Yes □ No
□□2 puffs □ 4 puffs of _____minutes before exercise

Long Term Control Daily Medications:_____

_____

Yellow Zone – immediate attention required.

Early warning signs of asthma may be seen;
* Cold symptoms and/or fever.
* Coughing/wheezing but able to do normal activity.
* Shortness of breath wit activity
* Chest tightness

OR

* Peak flow 50% to 80% of Personal best / predicted flow meter reading _____to_____
-Caution 50% to 80% if Personnel Best or Predicted Peak Flow Meter _____ to _____
Does student carry an inhaler? □ yes □ no If yes, type _____
(FHUSD form MA-3 must be signed by parent)
PLAN:_____

RED Zone – DANGER!!!!!

Immediate Treatment if Symptomatic or <50% of Predicted or personnel best peak flow below_____

Comments: Severe Symptoms _____
1st medication _____ **No** improvement in 15minutes_____
□2puffs□ 4 puffs □ by nebulizer x 1**Then:** If improvement in 15 minutes_____
Red Zone Treatment Medication _____
□2puffs □ 4 puffs □ by nebulizer x1
Notify Parent/guardian.
If student improves or peak flow meter is in the Yellow Zone: call physician to request further instructions.

OR

NO Improvement in _____ minutes **CALL 911**!

(FHUSD Form MA-5)(revised 2010)