FOUNTAIN HILLS UNIFIED SCHOOL DISTRICT
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 Aide and other authorized personnel.

☐ McDowell Mtn. School 480- 664-5201	☐ F.H. Middle School 480- 664 -5402	☐ F.H. 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 Fountain Hills Unified School District Asthmatic Management Plan.

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

Effective Date: ___/___/_____ Grade: _____ Homeroom Teacher: _____
(See attached schedule middle and high school students)

Birth Date: ___/___/_____

Date of Diagnosis: ___/___/____

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: _____/_____/_____

Cell Phone: _____/_____/_____ Work Phone: _____/_____/_____

Address: _____

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

_____

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

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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) ☐Cockroaches ☐Mold ☐Emotions (sad, happy)
☐Aerosols (hair spray, perfume)
☐Foods: _____
☐Other: _____

Middle School and High School students ONLY (Kindergarten to 5th grade to be individually evaluated with the 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 the health Office)

Parent/Guardian- 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(s)/Guardian(s) 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
☐Fountain Hills Middle School ☐Fountain Hills High School
To perform and carry out the asthmatic care task as outlined by _____'s
(Physician/Licensed Healthcare 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 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 healthcare provider for the school year 20___-20___.

I have read and received a copy of the FHUSD Asthmatic Management Plan, Policy and Procedure.

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

FOUNTAIN HILLS UNIFIED SCHOOL DISTRICT
Asthmatic Management plan

Asthmatic Care Plan for: _____

(Student's Name)

Physician or Licensed Healthcare Provider Plan of Care

(Completed by Physician or 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). Student ☐**will** use a peak flow meter at school (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 recuse inhaler with him/her during school and /or after school activity ☐Yes ☐No.

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

SVN (Small Volume Nebulizer)

Medication_____; _____ml in _____ ml of saline, every _____ hours.

☐May repeat in _____minutes with ☐same dosage OR ☐_____ml in _____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 in original prescription packaging) ☐Spacer ☐Peak Flow Meter

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

☐SVN mask or mouth piece, aerosol chamber and tubing ☐Inhaler for field trip use. (SVN's cannot be taken on field trips)

Signature:

_____ _____

Student's Physician/Licensed Healthcare Provider Date

_____ Phone Number _____-_____-_____

Printed name of Physician/ Licensed Healthcare Provider

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

Physician or Licensed Healthcare Provider Plan of Care (completed by Physician or 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 Physician or LHP Date

GREEN ZONE

Student's Personal best peak flow meter reading is _____ **or**
Student's predicted flow peak flow reading is _____ >80% of beat Predicted Peak Flow _____ to_____
Inhaler use before exercise ☐ YES ☐NO
☐2 puffs ☐4 puffs of _____, _____minutes before exercise.
Long Term Control Daily Medication: _____
_____

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 with activity.
- Chest tight

OR

- Peak Flow 50% to 80% of Personal best/predicted peak flow meter reading _____ to_____
- ❖ CAUTION 50% to 80% if Personal 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 personal best peak flow below _____

Comments: Severe symptoms _____
1st Medication _____ NO improvement in 15 minutes _____
☐2 puffs ☐4 puffs ☐by nebulizer x1 **Then: If improvement in 15 minutes _____**
Red Zone treatment Medication _____
☐2 puffs ☐4 puffs ☐by nebulizer x1
Notify Parent/guardian.
If student improves or peak flow meter is in the Yellow Zone: Call Physician or LHP to request further instruction.
OR NO Improvement in _____minutes, call 911.