Port Edwards Public Schools
801 Second Street
Port Edwards, WI 54469
Phone: 715-887-9000
www.pesd.k12.wi.us

Health Care Plan for Asthma Management

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:_____ **Student DOB: _____** **Grade**:_____

Student's Triggers of Asthma Episodes: (Check all that apply)

____Exercise ____Allergies
____ Respiratory Infections ____ Animals
____ Change in Temperature ____ Strong smells & chemicals
____ Stress ____Smoke
____ Other (Explain) _____

Scheduled Asthma Medication(s) for School

Name of medication:_____
Time to use:_____ How Often:_____
Other Directions:_____

Emergency Asthma Medication(s) for School

Name of medication:_____
When to use:_____ How Often:_____
Other Directions:_____
Physician Name: _____ Phone #: _____

Student may self carry and administer inhaler: ☐ Yes ☐ No

- *I authorize this medication to be administered at school, potentially by non-medically trained staff.*
- *I will supply medication in its original, updated, properly labeled container.*
- *I will obtain a new physician's order and notify the school in writing for any changes.*
- *I authorize school personnel to exchange information with my child's provider regarding this medication or the conditions for which it is prescribed.*
- *I understand the parent/guardian/responsible adult should deliver all medication to the school.*
- *I understand that this consent is in effect for the current school year (including summer school).*
- *I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.*
- *I consent to the release of the information contained in this Asthma Emergency Plan to staff members who may need to know this information to maintain my child's health and safety.*
- *I agree to hold the School District, its employees/ agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.*
- *My signature indicated I have fully read and understood the above information.*

AT THE END OF THE SCHOOL YEAR, PLEASE (circle one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE PROVIDER:*The above medication is to be administered in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure. I understand medication may be given by non-medically trained school personnel.*

This student may self-carry and self-administer medication: ☐ Yes ☐ No

Physician Signature: _____ Date: _____

Reviewed 5/2024

Asthma First Aid:

- **Remove student from the trigger**
- **Do not leave student alone**
- **Have student sit comfortably while leaning forward slightly, arms resting on thighs**
- **Give initial treatment and watch for improvement (typically within 5-10 minutes)**
- **Contact parent/guardian**
- **If symptoms did not improve with treatment, alert parent that student may need to seek medical attention**
- **If parent unable to arrive with in 10 minutes, call 911 for emergency transport**