

THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA

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)

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

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

