Oak Park School District
Asthma Management Plan

Child's picture

Student's Name: _____School Year: ____

School Attending: _____

DOB: _____ Grade: _____ Teacher: _____

Reviewed by: _____ on _____
(Healthcare Provider Signature) Date

Acknowledged by: _____ Cell #1: _____
(Parent/Guardian Signature) Cell #2: _____

Acknowledged by: _____on _____
(District Nurse Signature) Date

	Medication	Dose/Route
#1		
#2		
#3		

☐ Child authorized to carry and use inhaler ☐ Medication Authorization Form on file

Signs/Symptoms of Asthma may include:

1. Tightness in Chest
2. Shortness of Breath
3. Coughing for prolonged periods
4. Audible wheeze or unusual sounds
5. Anxious appearance
6. Need to stand or lean over at waist
7. Inability to speak without taking a breath or only able to whisper
8. Bluish discoloration of lips, nails, eyes or mouth
9. Coughing that causes choking, a bluish color to lips or vomiting
10. Decreased level of consciousness

Triggers/Symptoms (Specific to Student)	**Use Medication** (*Circle one*)			
	#1	**#2**	**#3**	
☐ **Allergic Reaction to:** →	**Yes**	**Yes**	**Yes**	**No**
☐ Exercise →	**Yes**	**Yes**	**Yes**	**No**
☐ Respiratory infection →	**Yes**	**Yes**	**Yes**	**No**
☐ Exposure to cold air →	**Yes**	**Yes**	**Yes**	**No**
☐ Emotional Stress →	**Yes**	**Yes**	**Yes**	**No**
☐ Other →	**Yes**	**Yes**	**Yes**	**No**

PARENT/GUARDIAN:

I request and give permission for (name of student)_____,
to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name and must be current.

_____ _____
Parent/Guardian Signature **Date**

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of Specialized Student Services at 248-336-7673.

DIRECTIONS FOR INHALER USE:

1. Allow the student to use his/her medication or be assisted by school personnel.
2. Student should respond to treatment in 15 to 20 minutes.
3. Encourage student's relaxation (e.g. slow breathing, deep breathing, purse lip breathing)
4. Notify parent/guardian if:_____
5. Call for Emergency Medical Care **(911)** if student has ***any*** of the following
   a. Constant Cough
   b. No improvement 15-20 minutes after initial treatment with medication and relative cannot be reached
   c. Any struggling or gasping to breath
   d. Trouble walking or talking
   e. Lips or fingernails are gray or blue

Bus Information to be completed by Parent/Guardian

Medication is to be available on the bus: Please circle ⇨ YES NO

If Medication ***IS*** to be available on the bus, I _____,

parent/guardian of _____ understand that I must provide an extra medication to be carried to and from school in the front pocket of the backpack-Transportation will be notified.

Acknowledged by District Nurse: _____ Date_____

Building Authorization:_____Date:_____

Total number of inhalers supplied to district: _____

☐ **School Office** ☐ **Classroom** ☐ **Other:_____**

Revised 5/20 cd