



# ASTHMA PLAN OF CARE

**IMPORTANT - THIS FORM MUST BE RETURNED TO E-VSC TO ALLOW YOUR PATIENTS WITH ASTHMA TO CARRY ASTHMA MEDICINES AT SCHOOL.**

## PARENT PORTION

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
Last Name First MI

School: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_ Phone (H): \_\_\_\_\_

Address: \_\_\_\_\_ Phone (W): \_\_\_\_\_

Emergency Phone Contact #1: \_\_\_\_\_  
Name Relationship Phone

Emergency Phone Contact #2: \_\_\_\_\_  
Name Relationship Phone

Primary Care Physician: \_\_\_\_\_ Other Physician Specialist \_\_\_\_\_

What are the specific triggers for your child's asthma? \_\_\_\_\_

## PHYSICIAN PORTION

### DAILY MEDS

- Breathing is good
- No cough wheeze
- Can work and play

<u>Daily Medicine</u>	<u>Amount</u>	<u>When To Use</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PRE-EXERCISE MEDS

Yes No

<u>Pre-Exercise Medicine</u>	<u>Amount</u>	<u>When To Use</u>
_____	_____	_____

### RESCUE MEDS

- Cough
- Wheezing
- Chest tightness
- Shortness of breath

<u>Rescue Medicine</u>	<u>Amount</u>	<u>When To Use</u>
_____	_____	_____
_____	_____	_____

### DANGER

- Medicine is not helping within 15-20 minutes
- Breathing hard and fast
- Chest or neck pulled in with breaths
- Lips/fingertips gray or blue
- Trouble walking or talking

1. GIVE EMERGENCY MEDICINES.
2. GET EMERGENCY HELP IMMEDIATELY!!
3. CONTACT PARENTS OR EMERGENCY CONTACTS.

[ ] This student is capable and has been instructed in the proper method of self-administering the medicines named above.

[ ] This student is not approved to self medicate

Physician Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_