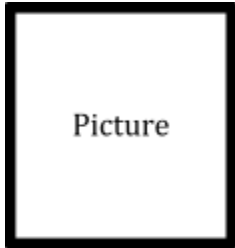




**Neenah Joint School District  
410 S Commercial St.  
Neenah, WI 54956**



Asthma Management and Emergency Plan

Student \_\_\_\_\_ Date \_\_\_\_\_ Grade \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_  
 Address \_\_\_\_\_ Parent/Guardian \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

**Emergency Contacts:**

Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

Will your child take asthma medication at school?  YES  NO

This student may carry and self-administer medication for asthma.

This student needs supervision and/or assistance with administration of asthma medication

What triggers your child's asthma?  Illness  Exercise

Allergies  Cold Air

Other (explain) \_\_\_\_\_

Describe your child's usual asthma symptoms:

Coughing  Shortness of breath

Nervous  Weakness

Itchy throat  Chest tightness

Other (explain) \_\_\_\_\_

**Instructions to follow if an asthma flare-up occurs at school:**

1. Give Medication:

Inhaler Type \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Expiration date \_\_\_\_\_

Nebulizer Type \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Expiration date \_\_\_\_\_

\* Prescription label must accompany inhaler either on inhaler or box.

2. If your child does not improve within 10-15 minutes what steps should the school staff take?

Contact Parent

Repeat treatment

Call 911 - list hospital of choice \_\_\_\_\_

Additional Comments \_\_\_\_\_

**-OVER-**

**Parent consent for management of health condition while at school or other school related activities**

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician Information**

Print Name of Provider \_\_\_\_\_ Clinic Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Address \_\_\_\_\_

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_