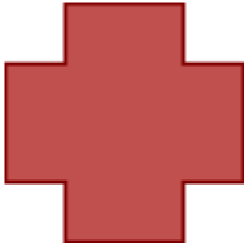
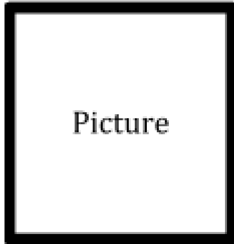


Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956



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___________________

Revised 4/2017