Asthma Management Plan

Name:_____DOB:_____Grade:_____

To Be Completed By Medical Provider:

_____must have the following medication during school hours in order to function at school:

☐ **Albuterol** ☐ **Other _____.**
For symptoms of coughing, wheezing, chest tightness and difficulty breathing, give medicine per dosing on front of sheet. If possible, remove from trigger and let rest in sitting position.

Albuterol/_____(other medicine) is a prescription drug. Possible side effects include increased activity, tremors, rapid hart rate and nausea. If these are significant, notify parent or _____(clinic/provider).

☐ Other_____

☐ I have instructed _____in the proper way to use his/her inhaled medications.

☐ Additional environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode:

_____

Physician/NP/PA Signature:_____ Date:_____ Phone:_____

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To Be Completed By Parent:

☐ I give my permission for my child, _____ to have school personnel administer his/her inhaled medications as indicated in the physician's order above.

I understand that:

- No Epiphany Board member, its employees and agents shall be liable in civil damages to any party for any act authorized or for any omission relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
- Information shared may be in the form of an emergency or individual care plan for my child and may include information provided by my child's physician, myself, or from records that have been released to the school from another agency.
- Exchange of information will be limited to the minimum necessary to provide the required assistance for my Child and will be shared only with those staff whom may need to provide the specified assistance for him/her.
- This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and providing Emergency Services (911).

If my child participates in before/after school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. Since the medication kept by the school is only available during regular school hours, I will provide extra emergency medications that may be needed during the activity. I authorize: The release and exchange of medical information between my child's physician, and the Epiphany School, their agents and their employees that is necessary in carrying out services for my child.

Parent Signature:_____Date:_____Phone:_____