

HCS School: _____ School Year: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN FOR ASTHMA WITHOUT MEDICATION AT SCHOOL

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan

SECTION I- Parent (Please Print)

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Emergency Contact:	_____	_____	_____	_____
	Name	Cell #	Home #	Work #

Emergency Contact:	_____	_____	_____	_____
	Name	Cell #	Home #	Work #

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ Policy/Group # _____
(optional) (optional)

SECTION II – Parent (Please Print)

The severity of symptoms can change quickly and potentially progress to a life threatening situation.
IF YOU SEE THIS... DO THIS...

<p>Student complains of:</p> <ul style="list-style-type: none"> • Tightness in chest • Coughing • Wheezing • Gasping for Air • Prolonged Expiration • Change in Color of Skin (Pale or Blue) 	<ol style="list-style-type: none"> 1. Allow student to rest and contact nurse if available 2. Call emergency contact 3. DO NOT leave student alone 4. Encourage slow deep breathing 5. Maintain student in sitting position 6. Sip cool water slowly 7. Document
<p>No Improvement:</p> <ul style="list-style-type: none"> • Student is hunched over • Has difficulty breathing • Is unable to speak • Uses neck/shoulder muscles to assist in breathing effort • Lips and/or nail beds are blue in color • Becomes unconscious 	<ol style="list-style-type: none"> 1. Call 911 2. Call emergency contact 3. DO NOT leave student alone 4. Encourage slow deep breathing, rest 5. Maintain student in sitting position 6. Document 7. Remain with student until EMS personnel arrives

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER
FIELD TRIPS: Supplies **should NOT be left** in a backpack on the bus or with a teacher who is not with the student.

BUS PLAN: Follow Emergency Plan, Pull Over, Call 911, and Call Parent/Guardian or Emergency contact

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

_____ Physician Signature	_____ Date	_____ Parent Signature	_____ Date	_____ Student Signature	_____ Date	_____ Nurse Signature	_____ Date
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