BUCKS COUNTY TECHNICAL HIGH SCHOOL
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Fairless Hills, PA 19030-4196
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School Nurses
215-949-1700, ext.2186 FAX: 215-949-8024

ASTHMA MANAGEMENT PLAN

Every Student who has asthma must have an Asthma Management Plan on file with the School Nurse. A student's asthma plan is developed by the student's healthcare provider, parent/guardian, and the student.

______________________ ________________ _________
Student's Name DOB Grade

________________________ ____________________________
Physician's Name Physician's Telephone Number

Asthma Emergency Action: *It is recommended that students keep a back-up inhaler in the Nurses Office*

Triggers or conditions that may worsen asthma symptoms:

____

____

Student's best Peak Flow reading (if used): ____

All Current Medications:

____

____

Medications To Be Given at School (if any) **To be completed by physician

Medication: _________________________________ Dosage:_____________________

Medication: _________________________________ Dosage:_____________________

Nursing Treatment for an Acute Asthma Episode ** To be completed by physician

1. ____
2. ____

****Student is competent and able to carry and self administer asthma medication.** ☐ **Yes** ☐ **No**

Physician Signature ____

Parent/Guardian Signature ____

Inhaler Self Administration

☐ **It is <u>not</u> necessary for the student to carry an inhaler in school**

Please complete this form if it is necessary for your student to carry an inhaler in school.

Student's Name ____ Grade ______________

To self administer in school, the student must be able to:

1. Respond and visually recognize his/her name,
2. Identify his/her medication,
3. Demonstrate the proper technique for inhaler self administration,
4. Demonstrate a responsible and cooperative attitude in all aspects of inhaler self administration.

Name of Medication ______________________________________

Dosage _________________________________ Frequency_______________________________

As the parent/guardian of the above named student, I certify that my child is capable of meeting the above criteria. I relieve the school and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use or sharing of the inhaler medication or other violation of the medication policy will result in the immediate confiscation of the inhaler and loss of privileges to self administer.

Parent/Guardian Signature _____________________________________ Date ________________

I agree to be solely responsible for my inhaler and follow the directions for its use as ordered by my physician as well as the school's medication policy. I will report to the School Nurse following the use of my inhaler. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

Student Signature ____ Date ________________

****Please Note:** If the parent/guardian has not signed the competency statement above, the student ***must*** demonstrate competency to the School Nurse as verified below.

The above named student has demonstrated the ability to self administer the physician prescribed inhaler medication as indicated by the criteria listed above.

School Nurse Signature ____ Date ______________