Hustisford School District

District Office	Jr./Sr. High School	John Hustis Elementary
845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-8109	845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-3261	600 S. Hustis. St · P.O. Box 386 Hustisford, WI 53034 (920) 349-3228
Heather Cramer District Administrator	**Clint Bushey** Principal	**Heather Cramer** Principal
Jessica Holtz Director of Financial Services	**Dena Serwe** Director of Special Education/Psychologist	

Health Care Plan for Asthma Management

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student Name:_____ Date of Birth:_____ Grade:_____

Triggers of Asthma Episodes:

____Exercise ____Allergies ____ Stress
____ Respiratory Infections ____ Animals ____ Smoke
____ Change in Temperature ____ Strong smells & chemicals
____ Other (Explain) _____

Symptoms of Asthma Episode:

____Wheezing _____ Cough
____ Shortness of Breath _____ Other: _____

Scheduled Asthma Medication(s) for School

Name of medication:_____
When to use:_____ How Often:_____
Other Directions:_____

Emergency Asthma Medication(s) for School

Name of medication:_____
When to use:_____
How Often:_____
Other Directions:_____

Provider Name: _____ **Phone Number:** _____

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

- I authorize that this medication/procedure be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist)
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information with my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this order/ consent is in effect for the current school year (may include summer school)..
- I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.
- I consent to the release of the information contained in this Asthma Emergency Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees/ agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicated I have fully read and understood the above information.

- My student may self-carry and self-administer inhaler: ☐ Yes ☐ No

Parent Signature: _____ **Date:** _____

TO BE COMPLETED BY THE PROVIDER:

PHYSICIAN ORDER: The above medication/procedure is to be administered/performed in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel. I have fully read and agree with the above information.

This student may self-carry and self-administer inhaler: ☐ Yes ☐ No

Physician Signature: _____ **Date:** _____

Asthma First Aid:

- **Do not leave student alone and remove them from trigger if possible**
- **Haves student sit comfortably while leaning forward slightly, arms resting on thighs**
- **Give initial treatment and watch for improvement (typically with in 5-10 minutes)**
- **Contact parent/guardian**
- **If symptoms did not improve, move to emergency medication, if available**

- **Alert parent that student may need to seek medical attention**
- **If parent unable to arrive with in 10 minutes, call 911 for emergency transport**