Fulton County Schools
Where Students Come First

Student Health Services

Asthma Health Care Plan

Student Name: _____ **Date of Birth**:_____

Teacher: _____ Grade: _____ School: _____

Severity Classification	Triggers	Exercise
○ Mild Intermittent ○ Mild Persistent ○ Moderate Persistent ○ Severe Persistent	○ Cold/Respiratory Infections ○ Exercise ○ Pollens ○ Weather ○ Food ○ Animals ○ Air Pollution ○ Dust ○ Smoke ○ Other _____	○ Pre-medication: _____ _____ ○ Exercise Modifications: _____ _____

- Immediate action is required when the student exhibits any of the following signs of an asthma attack:

Repetitive Cough Shortness of Breath Chest tightness Wheezing/Retractions Inability to speak in sentences

❖ **Steps to take during an asthma flare:** Give emergency asthma medication as listed below:

	Quick Relief Medication	Dose	Frequency
○	Albuterol MDI (Ventolin, Proventil, ProAir)		
○	Albuterol Nebulizer		
○	Albuterol RespiClick		
○	Xopenex HFA		
○	Xopenex Nebulizer		
○	Maxair MDI (Piruterol)		
○	Other:		

❖ **Activate EMS (call 911) IF the student has ANY of the following symptoms**

- Lips or fingernails are blue or gray
- The student is too short of breath to walk, talk, or eat normal
- Coughs constantly
- The student gets no relief within 10-15 minutes of quick relief medications OR the student has any of the following signs:
  - Persistent chest and neck pulling in with breathing
  - Student is hunching over
  - Student is struggling to breathe

Comments / Special Instructions: _____

_____

I am the parent/guardian of _____ and request that the Asthma Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Asthma Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____Phone # _____

Received by _____ Date:_____

Cluster Nurse/Special Education Nurse Signature: _____ Date: _____

Revised May 2019