EST. 1999

PRAIRIE CROSSING CHARTER SCHOOL

CREATING NATURAL LEADERS

_____

Date

2016 - 2017 Student Asthma Management Plan

This form must be returned to the school office no later than August 1, 2016.

_____/___/_____

Student's name (Last) (First) (Middle initial) Birth date Grade

_____ **My child does not have asthma.** (You do not need to fill out the following pages of asthma information.)

Symptoms of an asthma episode (circle all that may apply):

Wheezing Coughing Difficulty breathing Shortness of breath

_____

Other

Identify things that may trigger an asthma attack (circle all that may apply):

_____ _____

Abrupt temperature/weather change (specify) Exercise (specify)

_____ Respiratory infections Colds Prairie burns

Seasonal changes (specify)

My student is allergic to:

Mold Dust Pollen

Animals (specify) _____ Foods (specify)_____

Other (specify)_____

Prevention: List any environmental control measures, dietary restrictions, or other factors needed to prevent an Asthma episode:

_____.

Instructions: If school is unable to reach parent in an emergency, permission is granted to contact physician listed on this form, or to transport student to the emergency room. I/we understand that the above and following information will be released to staff members as appropriate, with the expectations that confidentiality will be respected at all times.

_____

Parent/guardian signature Date

1531 Jones Point Road
Grayslake, IL 60030-3536

847-543-9722 Phone
847-543-9744 Fax

_____/___/_____
Student's Name (Last) (First) (Middle initial) DOB

Asthma Management Plan
BELOW PERMISSION APPLIES ONLY TO SELF-ADMINISTRATION OF ASTHMA INHALERS
(To be completed by parent/guardian)

( ) No. ( ) Yes. The student is authorized by a physician to self-administer an asthma inhaler, and he/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Please note: All medication authorized for self-administration must be carried to school in a package with a prescription label including name of medication, prescribed dosage, and time/frequency of dosage.

Name of medication:

_____

I understand and acknowledge that I am primarily responsible for administering medication to my child. However, I give permission for Prairie Crossing Charter School and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of Prairie Crossing Charter School) the above medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practice. I understand that nothing in this form or elsewhere prohibits or prevents a Prairie Crossing Charter School employee or agent from providing emergency assistance to my child, including administering medication to the student in an emergency situation. I understand, however, that I should not rely on Prairie Crossing Charter School for the availability of emergency medication for my child, and that there is no guarantee that emergency medication will be available or accessible for my child in an emergency situation. I understand that it is my responsibility to consult a licensed provider to obtain all necessary medication and to ensure that the student has access to any necessary medication at school.

I further acknowledge and agree that, when medication is administered or attempted to be administered pursuant to this Form, including any self-administration by my child, or when any emergency assistance, as described above, is administered or attempted to be administered to my child, I waive any claims I might have against Prairie Crossing Charter School, its employees and agents arising out of the administration or self-administration of said medication other than for willful and wanton conduct. In addition I agree to hold harmless and indemnify Prairie Crossing Charter School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, self-administration, or attempts at administration or self-administration of said medication other than a claim based on willful and wanton conduct.

_____

Parent/guardian name (print) **Relationship to student**
Date

Parent/guardian signature **Emergency phone number** **Alternate phone number**

Adapted from ISBE & IDHS Recommended Guidelines for Medication Administration in Schools (September, 2000).
1511080.1

Revised 03/2016 *PCCS: LEW, RN*

_____/___/_____
Student's Name (Last) (First) (Middle initial) DOB

Asthma Management Plan
To Be Completed by Physician
(Please fill out the entire form)

_____

Medication Dosage Frequency

Medication Dosage Frequency

❑ **Grades 5-8:** Student may self-carry inhaler.

❑ **Grades 5-8:** Student has been instructed in proper use of inhaler(s) and may self-administer as needed.

_____

Date of order Expected side effects

_____

Other medications the student is receiving

****

Intervention Plan

Immediate action is necessary when the student has the following symptoms: _____

_____and/or a peak flow reading of _____ or below.

Contact the parent if symptoms persist. If unable to reach parent, seek emergency care if any of the following occur:

★ No improvement of symptoms in _____ minutes after initial treatment

★ Peak flow of _____ or below.

★ Difficulty walking, talking, or breathing with chest/tracheal retractions; hunched position

★ Skin, lips, or fingernails are blue or gray

Physical Education/Sports (please check all that apply):

❑ Full participation at all times; no asthma-related restrictions.

❑ Participation with the following restrictions/modifications: _____

_____

❑ Allow student to self-pace. ❑ Built in rest periods as needed. ❑ Peak flow above _____.

❑ An inhaler is considered part of the student's PE uniform. If a student does not have his/her inhaler, he/she will receive a zero for participation that day.

_____

Physician name (print) Physician's emergency phone number

_____

Physician signature Date