EVSC
Evansville Vanderburgh School Corporation

Asthma Plan of Care

IMPORTANT -THIS FORM MUST BE RETURNED TO EVSC TO ALLOW YOUR PATIENTS WITH ASTHMA TO CARRY ASTHMA MEDICATIONS AT SCHOOL.

PARENT PORTION

Name____ Grade________ Age__________
Last Name First MI

School____

Parent/Guardian Name____________________________________ Phone (H)____________________

Address____ Phone (W)____________________

Emergency Phone Contact #1____
Name Relationship Phone

Emergency Phone Contact #2____
Name Relationship Phone

Primary Care Physician_____________________________ Other Physician Specialist__________________________

What are specific triggers for your child s asthma?____

PHYSICIAN PORTION

DAILY MEDS

Breathing is good
No cough or wheeze
Can work and play

Daily Medicine	Amount	When to Use

PRE-EXERCISE MEDS

Yes No

Pre-Exercise Medicine	Amount	When to Use

RESCUE MEDS

Cough
Wheezing
Chest tightness
Shortness of breath

Rescue Medicine	Amount	When to Use

DANGER

Medicine is not helping within15 - 20 minutes
Breathing hard and fast
Chest or neck pulled in with breaths
Lips / fingertips gray or blue
Trouble walking or talking

1. **GIVE EMERGENCY MEDICINES**
2. **GET EMERGENCY HELP IMMEDIATELY!!!**
3. **CONTACT PARENTS OR EMERGENCY CONTACTS.**

( ) This student is capable and has been instructed in the proper method of self-administering the medicines above.
( ) This student is not approved to self-medicate

Physician signature & date______________________________ **Parent signature & date**______________________________
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Physician signature & date______________________________ **Parent signature & date**______________________________

Form revised: March, 2004