



Christian Liberty Academy

502 W. Euclid Avenue, Arlington Heights, Illinois 60004
(847) 259-4444 FAX (847) 259-9972



ASTHMA HEALTH CARE PLAN

STUDENT NAME: _____ D.O.B. _____ GRADE: _____

A review of health information completed by you indicated that your child has **ASTHMA**. In order for us to meet his/her health and safety needs in the school environment, it is important that you provide the following information. Please complete carefully, accurately, and completely. We will utilize this information in planning for and responding to any needs that become apparent during school hours.

Date of last exam for this condition: _____ Age at which **ASTHMA** was diagnosed: _____

MEDICATIONS:

Daily (dose and frequency)

As needed (indicate how frequently medication can be repeated)

Check if your child will keep this in the school office:

- Inhaler
- Peak Flow Meter
- Nebulizer
- Child's normal peak flow

IF MEDICATION IS REQUIRED AT SCHOOL, A SIGNED PRESCRIPTION MEDICATION FORM IS REQUIRED FOR EACH MEDICATION. If your child needs to carry any of the above, please complete the **PERMISSION TO CARRY FORM**.

SYMPTOMS THAT PERTAIN TO YOUR CHILD:

- "Tightness in chest"
- Shortness of breath
- Wheezing
- Breathing hard and fast
- Nasal flaring
- Coughing
- Choking or swelling in throat
- Other: _____

TRIGGERS THAT PERTAIN TO YOUR CHILD:

- Exercise
- Weather changes
- Pollens
- Upper respiratory infections
- Animal dander
- Emotions
- Irritants (chalk, smoke, paint)
- Other: _____

ASTHMA PROTOCOL:

1. Restrict physical activity and allow student to rest (sitting upright)
2. Encourage student to breathe slowly and deeply
3. Administer medication as ordered by physician
4. Offer warm liquids
5. If no improvement in 15-20 minutes OR IF CONDITION WORSENS, contact parents
6. If relative cannot be located and asthma is not improving, call 911

Indicate if there is anything different you would like Christian Liberty Academy to do in treating your child's asthma:

I give permission for this information to be shared with adults at Christian Liberty Academy on a need to know basis. *This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Nurse's Office whenever there is a change in my child's health status or care.*

Parent/Guardian Signature

Dated: _____

Signature of Health Care Provider with Prescriptive Authority

License Number of Health Care Provider

Printed Name of Health Care Provider

Phone Number

Dated: _____