

West Sonoma County Schools
School Nurse Services

Asthma Health Care Plan

Student's name _____ Date _____

School _____ Grade _____ D.O.B. _____

Dear Parent or Guardian,

You have indicated that your child has asthma. In order to meet your child's needs, please complete the following and return to the School Nurse.

Describe the symptoms your child experiences. (e.g., wheezing, coughing, tightness, other)

What triggers your child's asthma? _____

What usually helps when your child has an asthma episode? _____

What medications are taken? Medication at school requires the doctor and parent authorization.

At School Medication _____ Dosage _____ Time Given _____

_____ Dosage _____ Time Given _____

At Home Medication _____ Dosage _____ Time Given _____

_____ Dosage _____ Time Given _____

Doctor's name _____ Date of last evaluation _____

Does your child use a peak flow meter? If so, what is your child's current best peak flow numbers.

Does your child use a nebulizer at home? _____

Has your child been hospitalized for asthma? _____

Date of last hospitalization, (include emergency room visits) _____

Emergency Procedure for a Severe Asthma Episode

If a severe asthma episode were to happen at school this is the procedure the school will follow.

1. Student will sit upright and receive the prescribed medication.
2. Offer sips of warm water.
3. Reassure student and observe for response to medication.
4. Notify parent as needed.

If you would prefer a different procedure for your child please indicate below.

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____