Bristol School District #1
20121 83rd St.
Bristol, WI 53104

Asthma Management and Emergency Plan

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Will your child take asthma medication at school? ☐ YES ☐ NO

☐ This student may carry and self-administer medication for asthma.

☐ This student needs supervision and/or assistance with administration of asthma medication

What triggers your child's asthma? ☐ Illness ☐ Exercise
☐ Allergies ☐ Cold Air
☐ Other (explain) _____

Describe your child's usual asthma symptoms:
☐ Coughing ☐ Shortness of breath
☐ Nervous ☐ Weakness
☐ Itchy throat ☐ Chest tightness
☐ Other (explain) _____

Instructions to follow if an asthma flare-up occurs at school:

1. Give Medication:
   Inhaler Type _____ Dose_____ Frequency_____
   Expiration date_____
   Nebulizer Type_____ Dose_____ Frequency _____
   Expiration date _____
   * Prescription label must accompany inhaler either on inhaler or box.

2. If your child does not improve within 10-15 minutes what steps should the school staff take?
   ☐ Contact Parent
   ☐ Repeat treatment
   ☐ Call 911 - list hospital of choice _____
   ☐ Additional Comments _____
   _____

-OVER-

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____Date_____

Physician Information

Print Name of Provider_____Clinic Name_____
Phone Number_____Fax Number_____
Address_____

Signature of Provider_____Date_____

Revised 7/24