Kimberly Area School District
Health Services

425 S. Washington Street • PO Box 159 • Combined Locks, WI 54113
(920) 788-7900 • FAX (920) 788-7919 • www.kimberly.k12.wi.us

Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	

Health Condition: Respiratory- Emergency care for diagnosis of: _____ **Asthma**
_____ **Other** _____

Emergency Plan: Emergency action is necessary when the student has symptoms such as:

_____

_____

Or has a peak flow reading of _____.

Steps to take during a breathing emergency: DO NOT LEAVE STUDENT UNATTENDED!

1. Check peak flow (if student uses a peak flow meter)
2. Give medications as listed below. Student should respond to treatment in 15 to 20 minutes.
   - _____ Medication kept in school office.
   - _____ Student carries own inhaler at school
   - _____ No medication kept at school.
3. Contact parents if: _____
   _____
4. Recheck peak flow reading (if student uses a peak flow meter)
5. Seek **emergency medical help now** if the student has any of the following:
   - √ Coughs constantly
   - √ No improvement 15 to 20 minutes after initial treatment with medication and a relative cannot be reached.
   - √ Peak flow of _____
   - √ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Struggling or gasping
     - Nose flares open wide
     - Stooped body posture
     - Breathing is hard and fast
     - Ribs showing with breath
   - √ Can't walk/talk
   - √ Stops playing and can't start activity again
   - √ Lips or fingernails are grey or blue
   - √ Student has no inhaler available at school/activity

Emergency Medications:

	Name	Amount	When to use
1.			
2.			

Parent / Emergency Contact information:

	Name	Relationship to Student	Daytime Phone
1.			
2.			
3.			

(0ver)

Daily Management Plan:
Identify the things which start a breathing emergency (Check each that applies to the student.)

□ Exercise
□ Respiratory infections
□ Changes in temperature
□ Animals
□ Food _____
□ Strong odors or fumes
□ Chalk dust / dust
□ Carpets in the room
□ Pollens
□ Molds
□ Other _____
_____

Control of School Environment:
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an emergency episode:

_____

Peak Flow Monitoring: **Student has peak flow meter: _____ Yes _____ No** Personal Best Peak Flow number: _____
Monitoring Time/Number: _____ _____ _____ _____

Daily Medication Plan:

Name	Amount	When to use
1.		
2.		

FOR COMPLETION BY PHYSICIAN: **Physician's Name:** **Phone:**

Diagnosis:

Name of Medicine:

Form:	Dosage:

Is the child knowledgeable about his or her medication: ___Yes ___No

Has the child demonstrated the proper technique in administering medication: ___Yes ___No

Medicine is administered daily. ___Yes ___No	If yes, time:

Medicine is administered when needed. Indications:

If needed, how soon can administration of medicine be repeated?	The medication cannot be repeated more than:

Side effects:

( ) I have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that _____ should not carry and use his/her inhaled medication by him/herself.

Physician's Signature:	**Date:**

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer inhaled medications: Yes _____ No _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.
If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself.
I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

I have reviewed the health plan for my child: _____ The plan is correct as written _____ The plan is correct with the changes noted above

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, and office staff.
Elementary/Intermediate Students ONLY: Yes_____ No_____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice

Parent's Signature:	**Date:** Rev. 12/2015

Principal Initials: _____