# TOOELE COUNTY SCHOOL DISTRICT
# HEALTH CARE PLAN
# COVER SHEET

**Student's Name:** ______________________________________ **Date of Birth:** ___________

**School:** ________________________ **Grade:** ______ **Teacher:** _________________________

**Parent/Guardian:** ___________________________________ **Phone:** ____________________

**Address:** ______________________________________________________________________

**Other Emergency Contacts: #1)** __________________________________________________

**Name** **Phone**

**#2)** __________________________________________________

**Name** **Phone**

**Is student in Resource or Special Ed?** ☐ yes ☐ no

**Does student ride the bus?** ☐ yes ☐ no **Bus #____**

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**Doctor's Name:** ________________________________________________________________

**Telephone #:** _______________________________ **Fax #:** _____________________________

**Medical Diagnosis:** _____________________________________________________________

- ☐ **Student will carry/self administer medication**
- ☐ **School staff will store and administer medication**
- ☐ **No medication is required**

**Medication and/or medical supplies will be located at:**

- ☐ **Office**
- ☐ **Student's desk**
- ☐ **Locker**
- ☐ **Teacher's desk**
- ☐ **Student's backpack**
- ☐ **Other** ___________________________

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**I have read and approve student's healthcare plan.**

____________________________________ 
**Principal** **Date**

____________________________________ 
**School Nurse** **Date**

____________________________________ 
**Teacher/School Staff** **Date**

____________________________________ 
**Teacher/School Staff** **Date**

____________________________________ 
**Teacher/School Staff** **Date**

____________________________________ 
**Teacher/School Staff** **Date**

**ASTHMA – HEALTH CARE PLAN**

**Student's Name:** ___________________________________________________________________________

This Health Care Plan and the appropriate Utah Department of Health Asthma Self-Administration Form must be completed by the student's parent/guardian and/or their health care provider and returned to the school nurse or the school secretary. (The Health Care Plan should be individualized to meet the student's specific needs.)

Asthma is a chronic lung disease which is characterized by attacks of breathing difficulty caused by spasms of the muscles and increased mucous production in the air passages to the lungs. Asthma is not contagious but it does tend to run in families. There is no cure for asthma but it can be controlled with proper management and treatment.

**Problem:** Recognize known asthma triggers and early symptoms.
**Goal:** Avoid known asthma triggers and recognize early symptoms.
**Action:** The student will avoid known triggers and report early symptoms. (The student's parent/guardian and/or their health care provider should check the appropriate boxes.)

1. The student's known triggers include:
   - ☐ cold weather
   - ☐ pollen or dust exposure
   - ☐ exercise
   - ☐ viral infections
   - ☐ emotions
   - ☐ other ______________________________
2. The student's symptoms include:
   - ☐ coughing
   - ☐ tightness in chest
   - ☐ gasping for air
   - ☐ wheezing
   - ☐ color changes (pale or blue)
   - ☐ other ______________________________

**Problem:** Breathing difficulty caused by an asthma attack.
**Goal:** Prevent serious breathing difficulty by recognizing and treating early symptoms of an asthma attack.
**Action:** The student and school personnel will recognize and treat asthma symptoms appropriately.

1. Encourage the student to sit in an upright position and to lean slightly forward.
2. Reassure and encourage the student to be calm and breathe slowly and deeply.
   - ☐ Treat the symptoms with prescribed medication. If the student's medication is not with them, notify someone to immediately get the medication and bring it to the student.
3. Instructions for using a metered-dose inhaler to administer a medication used to treat the symptoms of asthma (i.e. wheezing, shortness of breath, trouble breathing, etc.) by increasing the flow of air through the bronchial tubes are as follows:
   - Remove the cap and hold the inhaler upright with the mouthpiece below the chamber.
   - Shake well.
   - Have the student tilt their head slightly back and breathe out.
   - Position the inhaler up to the student's lips **OR** Use the student's spacer as directed.
   - Press down on the inhaler to release the medication (you will hear a hissing noise).
   - Have the student breathe in slowly (three to five seconds) and deeply. This is referred to as a PUFF.
   - Have the student hold their breath for 10 to 20 seconds to allow the medication to stay in their lungs.
   - Wait one minute between prescribed puffs. Then repeat as directed. Do not give more than the prescribed number of puffs.
4. The student should respond to treatment within 15 to 20 minutes.
5. Contact the parent/guardian if there is **NO** change or if the student's breathing becomes significantly worse.
6. **Call 911 for emergency assistance if the student is getting rapidly worse.**
7. The student should continue to sit upright and rest until the medication takes effect.
8. The student should not be left unattended until the medication has taken effect and the symptoms have resolved.
9. Other ______________________________________________________________________________________________

**Problem:** Recognizing medication side effects.
**Goal:** Prevent serious outcomes from medication side effects.
**Action:** School personnel will recognize and respond to serious medication side effects appropriately. (The student's parent/guardian and/or their health care provider to check the appropriate boxes.)

1. More common side effects that usually do not require intervention unless they become troublesome or worrisome include: (Parent/guardian and/or health care provider to check the appropriate boxes.)
   - ☐ Nervousness
   - ☐ Restlessness
   - ☐ Trembling
2. Side effects that require immediate medical evaluation include: **(NOTE: Call 911 immediately and notify the parent/guardian and the school nurse if the student has any of these symptoms.)**
   - ☐ blue color to skin, lips or fingernails and/or clammy or cold skin
   - ☐ severe weakness, dizziness and/or fainting
   - ☐ increased breathing rate and/or heart rate
   - ☐ skin rash and/or swelling of face, lips or eyelids
   - ☐ seizures and/or loss of consciousness
   - ☐ severe muscle cramps and/or chest pain
   - ☐ chills and/or fever
   - ☐ severe nausea and/or vomiting
   - ☐ other ________________________________________

**Additional information:** ________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

**Tooele County School District**

**Utah Department of Health/Utah State Office of Education**

**Asthma Self-Administration Form**

in accordance with Utah Code 53A-11-602

______________________________________________________________________

Student Name Birth Date Grade/Teacher

__________________________________Tooele__________Utah________________84074______

Address City State Zip

**EMERGENCY CONTACT INFORMATION:**
**Name**________________________________________
**Phone:**____________________________________

**Health Care Provider Authorization**

The above named student is under my care. I feel it is medically appropriate for the student to self-administer inhaled asthma medication and be in possession of inhaled asthma medication at all times. The medication prescribed for this student is:

Name of Medication_______________________________________

Dosage_________________________________________________________

Possible Side Effects ______________________________________________

______________________________________________________________________

Signature of Health Care Provider Date

**Parent/Guardian Authorization**

☐ I authorize my child________________________ to carry and self-administer the medications described above consistent with Utah Code 53A-11-602.

☐ I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences for sharing any medications with others.

______________________________________________________________________

Parent/Guardian Signature

8/24/2004