

**Bedford County Public Schools**  
**Asthma Healthcare Plan & Medication Authorization**

Picture  
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**To be completed by parent/guardian**

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Primary # to call: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Primary # to call: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician Treating Student for Asthma: \_\_\_\_\_ Office #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What triggers your child's asthma attack?  
\_\_\_\_\_  
\_\_\_\_\_

Describe the symptoms your child experiences before/during an asthma episode:  
\_\_\_\_\_  
\_\_\_\_\_

**This section to be completed by health care provider.**

The child's asthma is: \_\_\_ persistent; \_\_\_ exercise induced; \_\_\_ intermittent; \_\_\_ other \_\_\_\_\_

Medication/treatment to be given at school:

Medication \_\_\_\_\_ Dose \_\_\_\_\_ When to use \_\_\_\_\_

Medication(s) given at home \_\_\_\_\_

Special instructions/restrictions at school: \_\_\_\_\_

\_\_\_ Student has been instructed in the proper use of his/her asthma inhaler, and in my opinion can carry and use the inhaler at school independently.

\_\_\_ Student needs assistance/supervision to use the inhaler.

\_\_\_ Student shall **NOT** be able to carry his/her inhaler while at school.

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Print provider name

\_\_\_\_\_  
Date

I give permission for school personnel to follow this plan, administer medication, care for my child and contact the physician if necessary. I assume full responsibility for providing the school with the medication and supplies needed. I will provide medical updates as indicated. I understand that this care plan is valid for the current school year only. I give permission to fax this form to my child's health care provider and the school clinic.

→ \_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*