Bedford County Public Schools

Asthma Healthcare Plan & Medication Authorization

Picture Here

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***