

Birmingham Covington School

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1525 Covington Road, Bloomfield Hills, MI 48301

Dear Parent/Legal Guardian,

You have indicated that your child has **Asthma** and may need assistance in the school setting.

In order for school personnel to safely care for your child in the event of an Asthma episode the following is required:

- 1. Emergency care plan for treatment of Asthma.**
- 2. School Based Asthma Management Plan.**
- 3. BPS Permission to Administer Medication Form.**

While we are willing to assist according to our district policy, we need direction from you and your child's health care provider. The enclosed Student Asthma Assessment and Emergency Plan will provide information that will help us in determining

- conditions that might trigger a flare up
- early symptoms and what should be done
- worsening symptoms and what should be done

Additionally, please note that when indicated it is the responsibility of the parent/guardian to

- maintain and cleanse equipment
- train student in usage of equipment
- assure medications have not expired
- communicate to school staff any change in medication orders and provide updated authorization for medication form
- return the enclosed forms

Enclosed you will find the appropriate forms to complete and return to the school office.

It is the parent/legal guardian's responsibility to provide all prescribed medications to the school. Please be advised that you are responsible for annual updates and for changes as they occur throughout the year.

Your prompt return of your child's information will assist us in responding more readily to your child's needs. Please return the completed packet to the school on or by the first day of school.

For further information or concerns, please contact the Public Health Nurse at the Oakland County Health Division, 248-424-7180.

Sincerely,

Adam Hartley

STUDENT ASTHMA ASSESSMENT AND EMERGENCY PLAN

Name _____ Date of Birth _____
 Teacher _____ Room _____

Parent(s) or Guardian(s)

Name _____ Phone (H) _____ Phone (W) _____ Pager/Cell _____
 Name _____ Phone (H) _____ Phone (W) _____ Pager/Cell _____

In case of emergency contact

Name _____ Relationship _____ Phone _____
 Name _____ Relationship _____ Phone _____

ASTHMA ASSESSMENT

Identify triggers that start an Asthma episode (check each that applies and specify).

<input type="checkbox"/>	Animals		<input type="checkbox"/>	Molds	
<input type="checkbox"/>	Dust/Mites		<input type="checkbox"/>	Pollens (with times of year)	
<input type="checkbox"/>	Chalk dust		<input type="checkbox"/>	Respiratory Infections	
<input type="checkbox"/>	Change of Season		<input type="checkbox"/>	Strong odors or fumes	
<input type="checkbox"/>	Exercise		<input type="checkbox"/>	Other	
<input type="checkbox"/>	Food				
			<input type="checkbox"/>	Comments	

Are any triggers life-threatening?	
Is your child on any Asthma medication?	
Any behavioral side effects to Asthma medications?	
Precautions in school environment to reduce frequency of episodes (e.g. activity restrictions).	
Comment/Special instructions (e.g. spacer, peak flow monitoring if prescribed by health care provider for use in school).	

Check all early warning signs.

- | | |
|---|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Itchy throat |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Feeling weak | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Funny feeling in chest | <input type="checkbox"/> Peak flow number from _____ to _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Irritability | _____ |

Worsening signs and symptoms are _____

When did they last occur? _____

If prescribed, peak flow number _____

SCHOOL-BASED ASTHMA MANAGEMENT PLAN

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

STUDENT INFORMATION

Child's Name: _____ Birth Date: _____

Grade: _____ Home Room Teacher: _____

Physical Education Days and Times: _____

EMERGENCY INFORMATION - TO BE-COMPLETED BY THE CHILD'S PARENT/GUARDIAN:

Parent/Guardian Name(s): _____

First Priority Contact: Name _____
Phone _____

Second Priority Contact: Name _____
Phone _____

Doctor's Name: _____ Phone: _____

TO BE COMPLETED BY THE CHILD'S DOCTOR:

WHAT TO DO IN AN ACUTE ASTHMA EPISODE:
1.
2.
3.

CALL 911 OR AN AMBULANCE IF: Review attached "Signs of an Asthma Emergency" and list any additional symptoms the child may present with:

DAILY MANAGEMENT PLAN - TO BE COMPLETED BY THE CHILD'S DOCTOR.

Child's Name: _____

Be aware of the following asthma triggers: _____

Severe Allergies: _____

MEDICATIONS TO BE GIVEN AT SCHOOL:

NAME OF MEDICINE	DOSAGE	WHEN TO USE

Side effects to be reported to health care provider: _____

Does this child have exercise-induced asthma? **Yes No**

Yes No This child uses an inhaler before engaging in physical exercise and if wheezing during physical activity.

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education):

Please circle Yes or No for each statement below:

Yes No I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child **should be allowed to carry and use** that medication by him/herself.

Yes No It is my professional opinion that this child **should not** carry his/her inhaled medications or epi-pen by him/herself.

Yes No Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or epi-pen.

Yes No I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: _____.

Doctor's Signature: _____ Date: _____

Parent/Guardian's Signature(s): _____ Date: _____

EMERGENCY PLAN

Steps to be taken during an Asthma episode:

- calm child
- encourage slow deep breathing exercises
- check peak flow number, if prescribed
- give medicine, if prescribed
- stay with child 15 minutes
- send child back to classroom if improved
- contact parent

These symptoms indicate the need for further emergency care.

- difficulty breathing, walking or talking
- blue or gray discoloration of lips or fingernails
- increasing anxiety

If any of these symptoms occur:

- call 911
- contact parent/guardian
- an adult stays with child until emergency contact person arrives
- give copy of this form and emergency recording to EMS or emergency contact person

We have read and agreed with the emergency plan.

Parent Signature

Date

Physician's Signature

Date

Signs of an Asthma Emergency

SEEK EMERGENCY CARE IF A CHILD EXPERIENCES ANY OF THE FOLLOWING:

- !! Child's wheezing or coughing does not improve after taking medicine (15-20 minutes for most asthma medications)
- !! Child's chest or neck is pulling in while struggling to breathe
- !! Child has trouble walking or talking
- !! Child stops playing and can not start again
- !! Child's fingernails and/or lips turn blue or gray
- !! Skin between child's ribs sucks in when breathing

Asthma is different for every person. The "Asthma Emergency Signs" above represent general emergency situations as per the National Asthma Education and Prevention Program 1997 Expert Panel Report.

If you are at all uncertain of what to do in case
of a breathing emergency...

Call 911 and the child's parent/guardian

Emergency Recording

(Send copy of this form with student to hospital)

1. Observed Asthma symptoms

2. Approximate time of onset

3. Name of medication given

- Amount of medication and how it was administered

- Date/time medication was administered

- Person who administered medication

4. Name of second medication if prescribed

- Amount of medication and how it was administered

- Date/time medication was administered

- Person who administered medication
