EVSC
Evansville Vanderburgh School Corporation
Bringing Learning to Life

Asthma Plan of Care

IMPORTANT – THIS FORM MUST BE RETURNED TO EVSC TO ALLOW YOUR PATIENTS WITH ASTHMA TO CARRY ASTHMA MEDICATIONS AT SCHOOL.

PARENT PORTION

Name____ Grade________ Age______
Last Name First MI

School____

Parent/Guardian Name______________________________ Phone (H) ______________

Address______________________________ Phone (W) ______________

Emergency Contact #1______________________________
Name Relationship Phone

Emergency Contact #2______________________________
Name Relationship Phone

Primary Care Physician______________________ Other Physician Specialist______________________

What are specific triggers for your asthma?______________________________

PHYSICIAN PORTION

DAILY MEDS
- Breathing is good
- No cough or wheeze
- Can work and play

→

Daily Medicine	Amount	When to Use

PRE-EXERCISE MEDS
Yes No

→

Pre-Exercise Medicine	Amount	When to Use

RESCUE MEDS
- Cough
- Wheezing
- Chest tightness
- Shortness of breath

→

Rescue Medicine	Amount	When to Use

DANGER
- Medicine is not helping within 15-20 minutes
- Breathing hard and fast
- Chest or neck pulled in with breaths
- Lips / fingertips gray or blue
- Trouble walking or talking

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1. **GIVE EMERGENCY MEDICINES**
2. **GET EMERGENCY HELP IMMEDIATELY!!!**
3. **CONTACT PARENTS OR EMERGENCY CONTACTS**

( )This student IS capable and has been instructed in the proper method of self-administering the medicines above.

( )This student IS NOT approved to self-medicate.

Physician signature & date______________________ **Parent signature & date**______________________

Form revised March, 2004