Discovery Woods

Dear Parent:

The Discovery Woods Staff want to promote a positive and healthy learning environment for each student. According to our records, your child is listed as having asthma or an asthmatic-like condition. So, with your help, we would like to plan for any necessary adjustments in the school day for your child with asthma. The intent of this plan is to promote wellness with control of asthma.

Please complete the attached form and return it to the Office. This information will be requested yearly and kept in the Health Record.

Students may keep their asthma inhalers with them if:

1. the parent gives written permission
2. the inhaler is properly labeled for that student
3. the student demonstrates appropriate use of the inhaler
4. a written order is received from the physician

If your child no longer has asthma symptoms, please return this form indicating that so we can update his/her school health record. Thank you for your time in assisting us to promote health and safety for your child.

DISCOVERY WOODS SCHOOL
604 North 7th Street, Brainerd, MN 56401
Phone:218-828-8200

HEALTH CARE/EMERGENCY PLAN
(Asthma)
School Year_____/_____

STUDENT INFORMATION:

STUDENT: _____ BIRTHDATE: _____

ICD Code: _____ SCHOOL_____ GRADE: _____

CONTACTS:

Parent/Guardian: _____ Home Phone: _____

Work #: _____ Cell/Pager: _____

Physician/Clinic: _____ Phone #: _____

MEDICATIONS:

			Home	School
Name: _____	Dose: _____	Time: _____	_____	_____
Name: _____	Dose: _____	Time: _____	_____	_____
Name: _____	Dose: _____	Time: _____	_____	_____

ALLERGIES: _____

TRIGGERS: (Check if applicable to your child.)

___ illness ___ stress ___ cold air ___ smoke ___ dust ___ exercise
___ other: _____

Severity of asthma (circle): Not severe 1 2 3 4 5 Severe

Peak Flow Meter reading personal best: _____

Days missed from school last year due to asthma: _____

Times treated in emergency room in past year due to asthma: _____

PLAN OF ACTION:

- Red Zone (acute episodes): _____
  - Peak flow reading: _____ to _____
- Yellow Zone (mild episodes): _____
  - Peak flow reading: _____ to _____
- Green Zone (Daily needs): _____
  - Peak flow reading: _____ to _____

CURRICULAR MODIFICATIONS REQUIRED (Explain) _____

_____

FIELD TRIP PLAN: _____

_____

(OVER)

EMERGENCY PLAN OF CARE:

1. **Call 911 if student has:**
    - **continued or severe difficulty breathing**
    - **difficulty talking**
    - **blue or gray discoloration of lips or fingernails**
2. **Call parent if student has a persistent cough that is not relieved by use of treatments available at school.**

Hospital of choice: _____

- **Student is authorized to carry medication in a metered dose inhaler and self-administer.**

_____ yes _____ no

- Parent signature: _____ Date: _____
- Physician signature*: _____ Date: _____
- Health Associate: _____ Date: _____

***Physician signature required only if this form is used as a doctor's order for medication(s) or treatment(s).**

- The school district intends to use the requested information to provide for your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed it may result in an incomplete health and safety plan for your child.
- Medications are not administered at school without physician and parent signatures.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success.

(MS Section 13.04, Subdivision 2)