Physician's Plan of Treatment: Asthma

Name of Patient: ______________________________ **DOB:** ____________________

Emergency Family Contact Names and Numbers:

______________________________ ______________________________
Name **Phone Number**

______________________________ ______________________________
Name **Phone Number**

Diagnosis: ASTHMA

1. For wheezing, severe cough, shortness of breath or other asthma symptoms, administer medication as listed on the attached "Parent Request & Physician's Order Form for Medication."
2. **IF significant symptoms of wheezing, severe cough, or shortness of breath persist after listed medication is administered, school personnel should activate emergency medical services and notify the student's family immediately.**
3. If symptoms resolve, notify parent and monitor for recurrence of symptoms. Any student requiring bronchodilator medication for a recurrence (second episode) of symptoms during the same day should be excluded from school for the rest of the school day.
4. Additional care recommended by child's physician as listed below:

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Duration of Order: School Year ______________________

Medications are kept in the front office (unless child is specifically authorized to self-administer asthma medication by physician). Please see "Authorized for Student to Carry and Self Administer Emergency Medication" form.

______________________________ ______________________________
Physician Name **Physician Phone Number**

______________________________ ______________________________
Physician Signature **Date**

School Staff Instructed: **Date & Time:**

______________________________ ______________________________

______________________________ ______________________________