EAGLE MOUNTAIN SAGINAW ISD
Fostering a Culture of Excellence

Eagle Mountain-Saginaw ISD
Health Services
Asthma Health Plan

Form Date: _____

Student Name:	**Grade Level**:	
DOB:	**Age**:	
Guardian #1:	**Relationship**:	**Phone**:
Guardian #2:	**Relationship**:	**Phone**:
Emergency Contact #1:	**Relationship**:	**Phone**:
Emergency Contact #2:	**Relationship**:	**Phone**:
Asthma Physician:	**Physician Phone**:	

Assessment Data (Check if Applicable)

Signs/Symptoms	Triggers		First Aid Interventions
☐ Wheezing	☐ Exercise	☐ Chalk/Markers	☐ Loosen Clothing
☐ Difficulty Breathing	☐ Cold Air	☐ Perfumes	☐ Administer Medication
☐ Chest Tightness	☐ Dust	☐ Smoke	☐ Encourage Relaxation
☐ Cough	☐ Stress	☐ Air Fresheners	☐ Encourage Pursed Lip Breathing
☐ Other:	☐ Infection	☐ Animals	☐ Administer Room Temperature Fluids
	☐ Allergies	☐ Other:	☐ Other:

Frequency of Asthma Episodes:	Number of Hospitalizations in Past 12 Months:

Current Medications: (Home/School/Both, including OTC and Alternative Meds)

Medication Name	Home/School	Route	Dose	Frequency
	☐ **Home** ☐ **School**			
	☐ **Home** ☐ **School**			
	☐ **Home** ☐ **School**			
	☐ **Home** ☐ **School**			
	☐ **Home** ☐ **School**			

Will student require nebulizer treatments at school? ☐ Yes ☐ No

For Inhaled Medications:

☐ I have instructed the student in the proper way to use his/her medications. It is my professional opinion that he/she **SHOULD NOT** be allowed to carry and use that medication by him/herself.

☐ It is my opinion that the student SHOULD carry his/her inhaled medication by him/herself. **MD SIGNATURE REQUIRED**

1. Student knows action of the medication and reason for taking medication.
2. Student is aware of the possible side-effects of medication.
3. Student agrees to never share medication with anyone.
4. Student will always carry medication in correct container.
5. Student agrees to go to the nurse's office if symptoms are not relieved by medication or if student has to use the medication more than twice a day.

If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

Physician Signature:	**Signature Date**:
Parent Signature:	**Signature Date**:
Student Signature:	**Signature Date**:
School Nurse Signature:	**Signature Date**: