LEXINGTON PUBLIC SCHOOLS

PHOTO

ASTHMA HEALTH CARE PLAN

Physician/Licensed Provider: complete this form or provide a Massachusetts Asthma Action Plan.

Student's Name: _____ Grade:_____ DOB:_____

Diagnosis_____

Known allergen(s): _____ Special Considerations: _____

Medication _____ Route _____

Dosage Prescribed _____ Time(s) to be administered _____

Date Medication to Begin _____
Note: Order valid for one (1) calendar year unless otherwise specified.

Special Instructions_____

Possible Side Effects _____

Medication _____ Route _____

Dosage Prescribed _____ Time(s) to be administered _____

Date Medication to Begin _____
Note: Order valid for one (1) calendar year unless otherwise specified.

Special Instructions_____

Possible Side Effects _____

List all medications used to control asthma: _____

Permission to self-administration of inhaler: □ Yes □ No Who taught student? _____

_____ _____
Physician/Licensed Provider Signature (including credentials) **Date**

_____ _____ _____
Physician/Licensed Provider Printed Name Telephone Address

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Dear Parents/Guardians:

I have read and reviewed the Asthma Health Care Plan formulated by my child's healthcare provider. I agree that it may be placed on file as a part of my child's school health record and the necessary information be shared with my child's teachers and staff. I also give permission for my child's school nurse to contact the Primary Care Physician, or provider completing this Asthma Health Care Plan, if further information or clarification is needed regarding the care of my child as stated in this plan. A back-up inhaler should always be kept in the School Health Room. I understand my child will self-administer their inhaler on field trips with permission from their healthcare provider and at the nurse's discretion. I attest that my child can perform self-administration with minimal assistance and supervision.

New Asthma Health Care Plans and updates may be submitted throughout the year with medication and/or treatment plan changes. If you have any questions about this policy, please contact your school nurse.

Sincerely,
Lexington Public School Nurses

Parent/Guardian Signature	**Date**	**Telephone**
Emergency Contact	**Relationship**	**Telephone**