LEXINGTON PUBLIC SCHOOLS
Lexington, Massachusetts

PHOTO MAY BE PLACED HERE

ASTHMA HEALTH CARE PLAN

Dear Parent/Guardian:

Your child has been noted to have a history of asthma as a part of their school health history. In order to ensure the best possible treatment, please have your child's physician formulate an **Asthma Health Care Plan** for school. The form must be filled out by the physician to allow your child to keep an inhaler on their person if allowed to self-administer per MD order.

Student's name: _____ **Grade:** _____

School: _____ **Room/Team**_____

Emergency contacts –PLEASE CIRCLE BEST NUMBER TO TRY FIRST:

Name_____**home**_____**work**_____**cell**_____

Name_____**home**_____**work**_____**cell**_____

To be completed by Physician

MD's name: _____ Phone # _____
(Please print)

Diagnosis: _____

Does this child have allergies? _____ To? _____

Special Considerations re allergies: _____

Does this child do Peak Flow Readings at home? _____

Peak Flow Readings: Normal _____ Call us at: _____

Medications used to control asthma: _____

Follow this Treatment Plan at school:

1. _____
2. _____
3. Is this medication required to go with student on Field Trips? _____ Yes _____ No

If Yes, the student must be instructed in the self-administration of inhaler. Did you teach the student how to self-administer their inhaler? ____Yes ____ No If no, who did? _____

_____

Primary Care Provider Printed Name Signature Date

A Massachusetts Asthma Action Plan may be substituted for this Asthma Health Care Plan

updated 6/7/23

Dear Physician and Parents/Guardians:

A back-up inhaler should always be kept in the School Health Room. At the elementary and middle school level the inhaler will be sent on all field trips as indicated above to ensure the safety of the student while away from the school building.

Please note that in Lexington, Emergency Medical Services are activated by a call to 911**. In the case of an emergency, the Lexington Fire Department transports to the nearest medical facility with an ED that is "Open" and is accepting patients**.

**New Asthma Health Care Plans and updates may be submitted throughout the year with medication and/or treatment plan changes.

Send this completed plan to:

_____RN, School Nurse

_____School

To all parents:

I have read and reviewed the Asthma Health Care Plan formulated by my child's physician. 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 physician completing this Asthma Health Care Plan, if further information or clarification is needed regarding the care of my child as stated in this plan. I understand my child will self-administer his/her inhaler on field trips. I have verified that my child can perform self-administration with minimal assistance and supervision.

_____ _____

Date Parent or guardian signature

____I have reviewed the above plan and have incorporated it in the student's school health record.

_____ _____ RN

Date School Nurse