

**LEXINGTON PUBLIC SCHOOLS**  
*Lexington, Massachusetts*  
**ASTHMA HEALTH CARE PLAN**  
**School Year August 2009- June 2010**

**PHOTO MAY BE PLACED  
HERE**

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 insure the best possible treatment, I would like you to have your child's physician formulate an **Asthma Health Care Plan** that I can follow. The usual **Medication Administration Form** must be filled out by the physician to allow your child to keep an inhaler in the school health room, or on their person if allowed to self-administrate per MD order. Please return that form with this plan.

Thank you, Your School Nurse

**Student's name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**School:** \_\_\_\_\_ **Room/Team** \_\_\_\_\_

Student's parents'/guardians' names:

\_\_\_\_\_ Home # \_\_\_\_\_ Wk# \_\_\_\_\_

\_\_\_\_\_ Home # \_\_\_\_\_ Wk# \_\_\_\_\_

Other contacts: cell# \_\_\_\_\_ beeper# \_\_\_\_\_

**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

I have instructed the student on how to self-administer the inhaler: \_\_\_\_\_ Yes \_\_\_\_\_ No

Further Instructions:

Date: \_\_\_\_\_ MD

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

Dear Physician and Parents/Guardians:

We urge if an asthma inhaler is prescribed for this student, that a back-up inhaler always be kept in the School Health Room. At the elementary and middle school level this will be sent on all field trips 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 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**

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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. **At the elementary level, I understand my child will be assisted to 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.

\_\_\_\_\_ Date

\_\_\_\_\_ School Nurse RN