

**Loudoun County Public Schools  
Physician Order/ Care Plan for Asthma**

**STUDENT'S NAME:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Homeroom Teacher:** \_\_\_\_\_ **Room#:** \_\_\_\_\_  
**Gender:** Male: \_\_\_\_\_ Female: \_\_\_\_\_ **Transportation:** Walker \_\_\_\_\_ Car \_\_\_\_\_ Bus#: \_\_\_\_\_  
**Physical Education Days and Time or Period (to be completed by school):** \_\_\_\_\_

**PHYSICIAN SECTION (Must be completed by Physician)  
DAILY ASTHMA MANAGEMENT PLAN**

Identify asthma triggers (*Check each that applies to this student*)

- |   |                                      |                               |
|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Pollens     | Personal best peak flow _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Molds       |                               |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Other _____ |                               |

Routine medication to be given at school. If more than one medication is to be given at same time, list in order to be given.

	Medication	Amount	When to use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:**

- |   |  |
|---|--|
| ✦ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached, or if condition worsens during this period.  | ✦ Difficulty walking or talking                |
| ✦ Peak flow less than _____   | ✦ Stops playing and can't start activity again |
| ✦ Difficulty breathing with: <ul style="list-style-type: none"> <li>• Chest and neck pulled in with breathing</li> <li>• Child is hunched over</li> <li>• Child is struggling to breathe</li> </ul> | ✦ Lips or fingernails are gray or blue         |

**EMERGENCY ASTHMA MEDICATIONS**

	Medication	Amount	When to Use	Route
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Time Interval for Repeating Dosage:

- ➔ if symptoms not relieved after initial dose \_\_\_\_\_
- ➔ if symptoms reoccur before next dose is due \_\_\_\_\_

It is my professional opinion that this student **SHOULD/SHOULD NOT** carry and use his/her inhaled medication by him/herself. I have instructed this student in the proper way to use these medications.

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Telephone Number

\_\_\_\_\_  
Physician's Printed Name \_\_\_\_\_ Fax Number

**PARENT/GUARDIAN SECTION**

Emergency Information: Parent/Guardian names: \_\_\_\_\_  
Telephone Number(s) Mother \_\_\_\_\_ Father \_\_\_\_\_ Emergency Contact with Phone# \_\_\_\_\_  
Home \_\_\_\_\_ ① \_\_\_\_\_  
Work \_\_\_\_\_ ② \_\_\_\_\_  
E-mail or Fax \_\_\_\_\_

*Parent's signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician if necessary.*

\_\_\_\_\_  
Parent/Guardian Signature Required Date