

**SCHOOL ASTHMA AND TREATMENT PLAN
BRIMFIELD CUST #309**

Student Name: _____ DOB: _____ Teacher/Grade: _____

Parent: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Restrictions: (ANY RESTRICTIONS MUST BE ACCOMPANIED BY A PHYSICIAN'S NOTE)

_____ no restrictions

_____ restrict outdoor exercise during: cold weather/ high humidity / high wind / other: _____

My child's asthma is: not a concern / mild / moderate / severe (circle one)

Triggers: cold air / exercise / hot humid weather / dust / pet dander / strong odors, perfumes /
grass, pollens / smoke / allergies / cold, flu / sudden temperature change / other _____

(Circle all that apply)

Symptoms include: coughing / wheezing / pain, tightness in chest / other _____

(Circle all that apply)

Worst time of the year: spring / summer / fall / winter/ all year

Medications taken: Reliever medication (name) _____

Controller medication (name) _____

Inhaler is used: only as needed/ before PE or physical activity

REMINDER: ALL INHALERS NEEDS A PHYSICIAN ORDER OR A COPY OF THE PHARMACY LABEL KEPT ON FILE AT SCHOOL

Does your child need a rescue inhaler at school? YES/NO

Does your child use a chamber with the inhaler? YES/NO

Is your child able to self administer inhaler? YES/NO

Location of inhaler: will carry inhaler / keep in locker or bookbag / keep in classroom with teacher

Brimfield School Dist. will permit the self administration of asthma inhaler medications for students with asthma provided that the parents or guardians acknowledge the school district is to incur no liability, except willful and wanton conduct, as a result of any injury arising from the self administration of medication by the student and the parents or guardians must indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self administration of medication.

Parent/Guardian Signature: _____ Date: _____