

Student Name _____



**Oxford Community Schools
ASTHMA Medical Action Plan (MAP)**

Student's Name _____

Date of Birth _____ **School** _____

Age _____ **Grade** _____ **School Year** _____

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to the school.

Child's
picture

CONTACT INFORMATION

Call First

Try Second

Parent/ Guardian:	Name: _____ Relationship: _____	Name: _____ Relationship: _____
Phone:	Home: _____ Cell: _____ Work: _____	Home: _____ Cell: _____ Work: _____

Call Third (If a parent /guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

ASTHMA HISTORY

Asthma Triggers- may cause an asthma episode at school (circle all that apply)

Exercise	Animal dander	Cold weather/extreme temperatures
Dust/carpet	Grass/pollen	Respiratory illness (colds)

Food _____ **Other** _____

A Severe Allergy Medical Action Plan has also been completed for this school year. **YES NO**

For asthma my child has/uses the following at home:

Medication (other than rescue) to control asthma	YES	NO
A nebulizer (breathing machine)	YES	NO
A spacer (attaches to an inhaler for ease of use)	YES	NO
A Peak Flow Meter	YES	NO

If my child is to self-carry a metered dose inhaler, I will still supply the school office with a back up inhaler. **YES NO**

I have received the attached information regarding Section 504 eligibility **YES NO**

I wish to be contacted regarding a 504 evaluation **YES NO**

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having asthma to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer medication ordered for asthma and to contact the physician/licensed prescriber for clarification of orders, if needed.

Date _____ Parent/Guardian _____
Signature

Bus #
Driver:
Transportation Office Use ONLY if needed
Route #
Medical File

Signs of Asthma Attack

- Wheezing (noisy breathing) * Peak flow reading below 80% of personal best
- Shortness of breath
- Difficulty breathing
- Coughing
- Complains of chest tightness or pressure

Action



- Give Medication as ordered below
- Use a spacer if provided for a metered dose inhaler
- Be sure to wait 1-2 minutes before a second puff of the inhaler
- Remain calm
- Encourage slow deep breathing: in through the nose & out through puckered lips
- Have the student sit upright
- Stay with the student until breathing normally

Signs of Asthma EMERGENCY

- No improvement 10-15 minutes after medication is given
- Breathing difficulty gets worse
- Skin pulls in around collarbone or ribs with each breath (shoulders may rise)
- Looks anxious, frightened, or restless
- Cannot talk in a complete sentence or walk and talk
- Stops playing and cannot start activity again
- Hunched over
- Pale color or blue around mouth or nail beds (skin may be damp)

Action



- CALL 911 and Parent/Guardian
- Repeat medication while waiting for emergency help to arrive
- Start CPR if breathing stops

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication _____ Route MDI (metered dose inhaler) Dose _____
 Nebulizer (breathing machine) Dose _____

MDI treatment may be repeated in 5 to 10 minutes if no help or symptoms worse YES NO

Nebulizer instructions _____

Medication is needed 20 minutes before PE/recess/strenuous exercise YES NO

Student can use inhaler correctly, knows when to get adult help, not to share, and how to properly maintain the device. Therefore, in my professional opinion, this student should be allowed to self-carry their inhaler. YES NO

Peak Flow readings are to be done at school YES NO Give medication for a PF reading below _____

Other instructions/orders _____

Physician/Licensed Prescriber Name _____

Phone number _____ FAX number _____

Signature _____ Date _____



Notice of Section 504 Procedural Safeguards

1. Have the District advise you of your rights under federal law;
2. Receive notice with respect to Section 504 identification, evaluation, educational program and/or placement of your child;
3. Have an evaluation, educational and placement decisions made for your child based upon information from a variety of sources and by a team of persons who are knowledgeable about the student, the meaning of evaluation data, and placement options;
4. Have your child receive a free appropriate public education, which is the provision of regular or special education and related aids and services that are designed to meet individual educational needs of your child as adequately as the needs of students without disabilities are met, if your child is Section 504 eligible;. If your child is Section 504 eligible, your child also has the right to have the District make reasonable accommodations to allow your child to an equal opportunity to participate in school and school-related activities;
5. Have your child be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;
6. Have your child take part in and receive benefits from the District's education programs without discrimination on the basis of disability;
7. Have your child educated in facilities and receive services comparable to those provided to non-disabled students;
8. Examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;
9. Receive a response from the District to reasonable requests for explanations and interpretations of your child's records;
10. Receive information in your native language and primary mode of communication;
11. Have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;
12. Have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;
13. Request and participate in an impartial due process hearing regarding the identification, evaluation, or placement of your child, including a right to be represented by counsel in that process and to appeal an adverse decision;
14. File a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.