GREER MIDDLE COLLEGE
CHARTER HIGH SCHOOL
HOME OF THE BLAZERS

Greer Middle College Charter High School Asthma Management Plan

School Year:_____

Student Name:	**Birthdate:**
Known allergies and asthma triggers:	
Asthma symptoms:	
RESCUE Medication:	**Spacer Recommended: Yes or No**

Prescription Information:

- ☐ **Give ___ puffs as needed for rescue treatment**
- ☐ **Give ___ puffs prior to PE and/or other strenuous activity (doses should be 4 hours apart)**
- ☐ **Sick Plan: Give ___puffs of scheduled rescue treatment every ___ hours and before PE and/or other strenuous activity.** ***(It is the responsibility of the parent/guardian to notify the school nurse of the student's need to be on the sick plan and for how long. If asthma symptoms do not improve after designated sick plan time frame, physician follow-up is highly recommended.)***

After rescue treatment administered:

1. **Observe student for twenty minutes or until breathing difficulty is relieved.**
2. **If a student is still experiencing breathing difficulty after 20 minutes, it is ok to repeat rescue treatment for a total of ____ times until breathing difficulty subsides.**

ROUTINE Asthma Control Medication (at home):_____

Licensed Health Care Providers Read Carefully:
Student has permission to self-carry/self-administer this medication: ☐ Yes ☐ No

If yes, I agree that this student must be allowed to have the above-named medication on his/her person during school hours, in transit to and from school-sponsored activities, before and after school activities on school property and any school sponsored activity. This child has been instructed regarding the appropriate use of the medication and has demonstrated competency in self-monitoring and self-administration of this medication. The parent is aware that they cannot hold the school responsible for any adverse outcome of this action.

Licensed Health care provider name (printed):_____**Phone:**_____

Licensed Health care provider signature:_____**Date:**_____

Parents/legal guardian please read below: By signing, you agree to the following:

- **I agree with the school and home asthma management plan.**
- **My child has permission to use the above named medication/device at school as described above.**
- **I agree to communicate any changes in my child's asthma condition and management plans.**
- **I understand that all medications must be in the original container issued by the pharmacist with the most recent label. Also, I am responsible for replacing any expired medication.**
- **I give my permission for designated staff at the school to administer this medication to my child according to school requirements.**
- **I give my permission for the principal, school nurses, and/or health services to share this information with individuals who have responsibility for my child.**
- **My child has worked closely with the physician and demonstrated competency and may self-administer and self-carry the above medication. The first dose of the medication has been given at home.**
- **I understand that my child may lose the privilege to self-monitor/self-administer if he or she endangers himself or another student by misusing the device/medication.**
- **The school is not liable for any injury arising from administration of medication authorized by an IHP(Individual Health Plan) or licensed health care provider. As a parent/guardian, I shall indemnify and hold harmless the school against a claim arising from administration of medication authorized by an IHP or licensed health care provider.**

Parent/Legal Guardian Signature:_____**Date:**_____

Printed Parent/Legal Guardian Name:_____**Phone:**_____

This form is only valid if signed on or after July 1st for the upcoming school year.