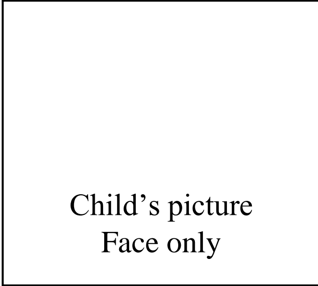
Student Name____Attachment C

Madison District Public Schools
ASTHMA Medical Action Plan (MAP)


Child's picture
Face only

Student's Name____
Date of Birth__________**School**_________________________________
Age________**Grade**_________ **Teacher** _________________

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.

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

CONTACT INFORMATION

	Call First	**Try Second**
Parent/ Guardian:	Name: ____________	Name: ____________
	Relationship: ____________	Relationship: ____________
Phone:	Home: ____________	Home: ____________
	Cell: ____________	Cell: ____________
	Work: ____________	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 Allergy(s)_________________________________**Other**______________________

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

For asthma my child has/uses the following:

☐**YES** ☐**NO** A spacer
Recommended for **all** students, attaches to the inhaler for ease of use and improved delivery of the medication to the bronchi.
☐**YES** ☐**NO** Medication at home (other than rescue) to control asthma
☐**YES** ☐**NO** A nebulizer (breathing machine) at home
☐**YES** ☐**NO** I will supply the school with a back up inhaler if my child is to self carry.
☐**YES** ☐**NO** I have read the attached information regarding section 504 eligibility
☐**YES** ☐**NO** I wish to be contacted regarding a 504 evaluation

Instructions for the school____

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. 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 the medication ordered for asthma on page 2 of this plan and to contact the physician/licensed prescriber for clarification of orders, if needed.

Date____________________Parent/Guardian____
Signature

Signs of Asthma Attack

- **Wheezing (noisy breathing)**
- **Shortness of breath**
- **Difficulty breathing**
- **Coughing**
- **Complains of chest tightness or pressure**

*** Peak flow reading below 80% of personal best**

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 up right**
- **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**

For office use: Rescue inhaler location____Expiration date______________

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

Medication_________________________________**Route** **MDI (metered dose inhaler)** **Dose** _______________
□ **Nebulizer(breathing machine) Dose**_______________

Side Effects____

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

Nebulizer instructions____

□ **YES** **NO** 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 devise. Therefore, it is my professional opinion, this student should be allowed to self-carry their inhaler.

□ **YES** **NO** Peak Flow readings are to be done at school. Give medication for a PF reading below_____________

Other instructions/orders____

Physician/Licensed Prescriber Name (Print) ____

Phone number_________________________________**FAX number** ________________________________

Signature____**Date** ___________________________________

MADISON
DISTRICT PUBLIC SCHOOLS
Serving Families One Student at a Time

NOTICE OF SECTION 504 PROCEDURAL SAFEGUARDS FORM C

The following is a brief summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, and some related rights provided by Title VI of the Civil Rights Act of 1964 and the Family Educational Rights and Privacy Act. The intent of the law is to keep you fully informed about decisions concerning your child and to inform you of your rights in the event you disagree with any decisions concerning your child. You have the right to:

1. have the District advise you of your rights under federal law;

2. receive notice with respect to Section 504 identification, evaluation, and/or placement of your child

3. have an evaluation and placement decision for your child based upon information from a variety of sources and which is made by a team of persons 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 the child is Section 504 eligible;

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 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 information in your native language and primary mode of communication;

I 0. have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;

1 1. have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;

12. 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;

13. file a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.