

GASTON COUNTY SCHOOLS
PHYSICIAN ORDER AND TREATMET PLAN FOR STUDENT WITH ASTHMA
 (This form replaces the Authorization of Medication for Students in School Form.)

STUDENT'S NAME _____ BIRTHDATE _____
 DIAGNOSIS _____

TREATMENT PLAN

MEDICATION/DOSAGE _____
 INDICATIONS/INSTRUCTIONS _____

MEDICATION/DOSAGE _____
 INDICATIONS/INSTRUCTIONS _____

EXERCISE/ACTIVITY MODIFICATIONS _____

Student understands and has been instructed in self-administration of the asthma medication. YES/NO
 Student has demonstrated the skill level necessary to use the asthma medication and any device that is necessary to administer asthma medication. YES/NO

EMERGENCY PLAN

- CALL 911 IF:
- LIPS, NAILBEDS OR FACE BECOME BLUE
 - BREATHLESSNESS CAUSES STUDENT TO TALK IN 1-2 WORD SENTENCES OR NOT AT ALL
 - BREATHING STOPS

ADDITIONAL COMMENTS _____

I hereby give permission for school personnel to contact my child's physician and exchange information regarding my child's health needs.

Parent/Guardian (Signature)	date	Health Care Provider (Signature)	date	Printed Physician name or clinic stamp
		Telephone #		

School Nurse Signature _____ Date _____

Session Law 2005-22, House Bill 496, chapter 115c, article 26a-375.2). If a student uses asthma medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the schools disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication.

4/09