

**St. Matthew School  
Health Care Plan  
Inhaler—non asthma**

Student's Name \_\_\_\_\_ Grade/teacher \_\_\_\_\_

Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

**Action Plan**

Actions to be taken:

\_\_\_\_\_

Medication, Dosage and Frequency \_\_\_\_\_

Medication to be given before any activities \_\_\_\_\_

Signs and Symptoms your child typically exhibits when needing to use the inhaler: \_\_\_\_\_

Environmental concerns \_\_\_\_\_

Restrictions \_\_\_\_\_

Parent Contact \_\_\_\_\_

MD contact in emergencies \_\_\_\_\_

School nurse will provide the following information to school staff

\_\_\_\_\_

\_\_\_\_\_

Medication delivered to school \_\_\_\_\_

Parent will attach a copy of the prescription order for the inhaler/nebulizer (pharmacy label on inhaler box will suffice) to this action plan.

Parent initials \_\_\_\_\_

I give permission for my child to be given the above care

Parent signature \_\_\_\_\_

Date \_\_\_\_\_

MD signature \_\_\_\_\_

School nurse signature \_\_\_\_\_

Date \_\_\_\_\_