ASTHMA MANAGEMENT PLAN
SCHOOL YEAR:

STUDENT: _____ **BIRTHDATE:**_____
SCHOOL: _____ **STUDENT ID:**_____

MOTHER:	**FATHER:**	
HOME PHONE:	**HOME PHONE:**	
WORK:	**WORK:**	
CELL:	**CELL:**	
EMERGENCY CONTACT:	**PHONE:**	
PHYSICIAN:	**PHONE:**	**FAX:**

MEDICATIONS TAKEN AT HOME:

Medication Name:	Dose:	Time:

SCHOOL MANAGEMENT OF ASTHMA:

GREEN ZONE- GOOD	YELLOW ZONE- CAUTION	RED ZONE-DANGER
If student has ALL of these: • **Breathing is easy** • **No Cough or wheeze** • **Can play and work** **NO TREATMENT NEEDED** **If in GREEN ZONE BUT <u>EXERCISE</u> MAY CAUSE ASTHMA SYMPTOMS, USE:** Use_____ **(name of medication)** _____ puffs _____ minutes before exercise	**If student has ANY of these:** • **First sign of a cold** • **Cough or mild wheeze** • **Tight chest** • **Problems with work or play** □ **Use _____,** **(name of medication)** **_____ puffs inhaler every _____ hours as needed** **OR** □ **Use _____,** **(name of medication)** **_____ nebulizer treatment every _____ hours as needed** □ **Other treatment needed:** _____ _____	**If student has ANY of these:** • **Can't talk, eat, or walk well** • **Medicine is not working** • **Breathing hard and fast** • **Blue lips and fingernails** • **Tired or lethargic** • **Skin around neck and ribs pulls in** **Call 911 then contact parent.**

<u>This section is to be completed by a **Physician** IF</u> student is to possess and self-administer medication in school at a school sponsored activity; while under the supervision of school personnel; or before, during, or after school care on school operated property, (in compliance with SB 472, effective 7/01/02).

<u>FOR INHALED MEDICATIONS:</u> (Please check one of the options below)

1. _____I have instructed this student in the proper use and dosage of his/her inhaled medication. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself.
   <u>OR</u>
2. _____This student is <u>not</u> approved to self-medicate.

_____ _____
Physician Signature Date

_____ _____ _____ _____
Parent Signature Date County School Nurse Signature Date

Confidentiality of student information should be maintained at all times.