



ASTHMA MANAGEMENT PLAN

SCHOOL YEAR: _____

Student Name:		DOB:	
School:		Student ID:	
CONTACTS:			
Parent/Guardian:		Parent/Guardian:	
Phone:		Phone:	
If parents cannot be reached call:			
Name:		Phone:	
Physician:		Phone:	
Hospital Preference:			
Medication Name (include those taken at home):		Dose:	Time:
SCHOOL MANAGEMENT OF ASTHMA:			
<p style="text-align: center;">GREEN ZONE- GOOD</p> <p>If student has ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No Cough or wheeze Can play and work <p>NO TREATMENT NEEDED</p> <p>If in GREEN ZONE BUT EXERCISE MAY CAUSE ASTHMA SYMPTOMS, USE:</p> <p><input type="checkbox"/> Use _____ (name of medication) _____ puffs _____ minutes before exercise.</p>	<p style="text-align: center;">YELLOW ZONE- CAUTION</p> <p>If student has ANY of these:</p> <ul style="list-style-type: none"> First sign of a cold Cough or mild wheeze Tight chest Problems with work or play <p><input type="checkbox"/> Use _____, (name of medication) _____ puffs inhaled every _____ hours as needed.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> Use _____, (name of medication) _____ nebulizer treatment every _____ hours as needed.</p>	<p style="text-align: center;">RED ZONE- DANGER</p> <p>If student has ANY of these:</p> <ul style="list-style-type: none"> 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 <p style="text-align: center;">Call 911 then contact parent.</p>	
<p><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).</p> <p><u>FOR INHALED MEDICATIONS:</u> <i>(Please check one of the options below)</i></p> <p>1. _____ I have instructed this student in the proper use and dosage of the inhaled medication. It is my opinion that this student may carry and self-administer the inhaled asthma medication.</p> <p>2. _____ This student is NOT approved to self-administer the inhaled asthma medication.</p>			
Physician Signature _____		Date _____	

School Clinic: Copy of this plan should be provided to Transportation Supervisor.

PARENT SIGNATURE / DATE

COUNTY SCHOOL NURSE SIGNATURE / DATE

Information about students and family is strictly confidential.