Clinic Use LOCATION OF EMERGENCY MEDICATION AT SCHOOL: _____ Self-Carry □ Location:_____

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:

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 EXERCISE 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.**	**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.**

This section is to be completed by a Physician IF 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).

FOR INHALED MEDICATIONS: *(Please check one of the options below)*

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.
2. _____ This student in NOT approved to self-administer the inhaled asthma medication.

_____ _____
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.

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