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.

Rev. 3/2023

ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ Date of Birth: _____
STUDENT NUMBER: _____ TEACHER: _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: _____ Expiration Date: _____

Reason Medication Given: _____

Amount to be Given: _____

Time(s) to be Given: _____

Possible Side Effects: _____

Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____Work: _____ Cell: _____

_____ _____
Signature of Parent Date

FOR CLINIC USE: ☐ Medication disposed of By _____ Date _____
☐ Medication picked up By_____Date_____
(parent signature)

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