ASTHMA MANAGEMENT PLAN
SCHOOL YEAR:

Student Name:	**DOB:**
School:	**Student ID:**
CONTACTS:	
MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
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 <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.
2. _____This student is <u>not</u> approved to self-medicate.

_____ _____

Physician Signature Date

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

_____ _____

PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Confidentiality of student health information should be maintained at all times.

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