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.
   <u>OR</u>
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 must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.