



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:

<p>GREEN ZONE- GOOD 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>Use _____ <small>(name of medication)</small> _____ puffs _____ minutes before exercise</p>	<p>YELLOW ZONE- CAUTION 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 _____, <small>(name of medication)</small> _____ puffs inhaled every _____ hours as needed</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> Use _____, <small>(name of medication)</small> _____ nebulizer treatment every _____ hours as needed</p> <p><input type="checkbox"/> Other treatment needed: _____</p>	<p>RED ZONE-DANGER 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>
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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)

- _____ 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.
OR
- _____ This student is not 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