ASTHMA MANAGEMENT PLAN
SCHOOL YEAR:

STUDENT: ______________________ BIRTHDATE: ______________________
SCHOOL: ______________________ STUDENT ID: ______________________

MOTHER:	FATHER:
HOME PHONE:	HOME PHONE:
WORK:	WORK:
CELL:	CELL:
EMERGENCY CONTACT:	PHONE:

PHYSICIAN:	PHONE:	FAX:

MEDICATIONS TAKEN AT HOME:

Medication Name:	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).

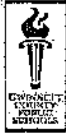
<u>FOR INHALED MEDICATIONS:</u> (Please check one of the options below)

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

______________________________ ______________________________
Parent Signature Date County School Nurse Signature Date

Confidentiality of student information should be maintained at all times.



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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