



# ASTHMA MANAGEMENT PLAN

**SCHOOL YEAR:** \_\_\_\_\_

<b>Student Name:</b>	<b>DOB:</b>
<b>School:</b>	<b>Student ID:</b>
<b>CONTACTS:</b>	
<b>MOTHER:</b>	<b>FATHER:</b>
<b>HOME:</b>	<b>HOME:</b>
<b>WORK:</b>	<b>WORK:</b>
<b>CELL:</b>	<b>CELL:</b>
<b>If parents cannot be reached call:</b>	
<b>Name:</b>	<b>Phone:</b>
<b>Name:</b>	<b>Phone:</b>
<b>Physician:</b>	<b>Phone:</b>
<b>Hospital Preference:</b>	

Medication Name (include those taken at home):	Dose:	Time:

<b>SCHOOL MANAGEMENT OF ASTHMA:</b>		
<p style="text-align: center;"><b>GREEN ZONE- GOOD</b></p> <p><b>If student has ALL of these:</b></p> <ul style="list-style-type: none"> <li>Breathing is easy</li> <li>No Cough or wheeze</li> <li>Can play and work</li> </ul> <p><b>NO TREATMENT NEEDED</b></p> <p><b>If in GREEN ZONE BUT <u>EXERCISE</u> MAY CAUSE ASTHMA SYMPTOMS, USE:</b></p> <p>Use _____  <span style="margin-left: 40px;">(name of medication)</span>            _____ puffs            _____ minutes before exercise</p>	<p style="text-align: center;"><b>YELLOW ZONE- CAUTION</b></p> <p><b>If student has ANY of these:</b></p> <ul style="list-style-type: none"> <li>First sign of a cold</li> <li>Cough or mild wheeze</li> <li>Tight chest</li> <li>Problems with work or play</li> </ul> <p><input type="checkbox"/> Use _____,  <span style="margin-left: 40px;">(name of medication)</span>            _____ puffs inhaler every            _____ hours as needed</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Use _____,  <span style="margin-left: 40px;">(name of medication)</span>            _____ nebulizer treatment            every _____ hours as needed</p> <p><input type="checkbox"/> <b>Other treatment needed:</b>            _____</p>	<p style="text-align: center;"><b>RED ZONE-DANGER</b></p> <p><b>If student has ANY of these:</b></p> <ul style="list-style-type: none"> <li>Can't talk, eat, or walk well</li> <li>Medicine is not working</li> <li>Breathing hard and fast</li> <li>Blue lips and fingernails</li> <li>Tired or lethargic</li> <li>Skin around neck and ribs pulls in</li> </ul> <p style="text-align: center;"><b>Call 911 then contact parent.</b></p>

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 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 not approved to self-medicate.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PARENT SIGNATURE / DATE

\_\_\_\_\_  
COUNTY SCHOOL NURSE SIGNATURE / DATE

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