



# 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>			
<b>Medication Name (include those taken at home):</b>		<b>Dose:</b>	<b>Time:</b>
<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 EXERCISE MAY CAUSE ASTHMA SYMPTOMS, USE:</b></p> <p>Use _____  <small>(name of medication)</small>        _____ 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 _____,  <small>(name of medication)</small>        _____ puffs inhaled every _____ hours as needed</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Use _____,  <small>(name of medication)</small>        _____ 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>	
<p>This section is to be completed by a <b>Physician</b> 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).</p> <p><b>FOR INHALED MEDICATIONS:</b> (Please check one of the options below)</p> <p>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.</p> <p style="text-align: center;"><b>OR</b></p> <p>2. _____ This student is <u>not</u> approved to self-medicate.</p>			
Physician Signature _____		Date _____	

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

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

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