ASTHMA MANAGEMENT
STUDENT HEALTH CARE PLAN
(to be completed by parent and physician)

Student Information

STUDENT NAME _____ Date_____
Teacher/Grade_____ DOB_____

Emergency Information

Parent/Guardian: Name_____Phone(H)_____
Address_____Phone (W)_____
Parent/Guardian: Name_____Phone (H)_____
Address_____Phone (W)_____
Emergency Contact #1: _____
Name Relationship Phone
Emergency Contact #2: _____
Name Relationship Phone
Physician_____Phone_____

Daily Management Plan

* Triggers (Check each that applies)
____Exercise ____Respiratory infections ____Change in temperature
____Animals ____Food_____ ____Strong odors or fumes
____Chalk dust ____Carpets in the room ___Pollens ____Molds

* Control of Environment (List any environmental control measures, pre-medications, and/or dietary restrictions)_____
_____

* Daily Medication
Name Amount When to Use
1._____
2._____
3._____

* Peak Flow Monitoring
Personal Best Peak Flow #_____Monitoring times_____

* The child has demonstrated the proper technique in administering medication and is authorized by the physician to carry the inhaler and self administer it: _____YES _____NO

Emergency Plan

* Give emergency medication:_____
* Notify parent
* Call 911 if any of the following signs of an asthma emergency occur:
*No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
*Peak flow of_____
*Difficulty breathing, walking, or talking
*Blue or gray discoloration of the lips or fingernails

* I agree with the above plan of action in the treatment and management of asthma in the above named student:

Physician Signature_____**Date**_____

Parent Signature_____ **School Nurse**_____