Tri County Area Schools
Tradition • Character • Achievement • Success

This information expires on June 30, _____

SCHOOL BASED ASTHMA MANAGEMENT PLAN

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

STUDENT INFORMATION

Child's Name: _____ Birth Date: _____

Grade: _____ Homeroom Teacher: _____

Physical Education Days and Times: _____

EMERGENCY INFORMATION

*To be completed by the child's parent/guardian

Parent/Guardian Names: _____

_____

First Priority Contact: Name: _____

Phone: _____

Second Priority Contact: Name: _____

Phone: _____

Doctor's Name: _____ Phone Number: _____

*To be completed by the child's health care provider

WHAT TO DO IN AN ACUTE ASTHMA EPISODE:

_____

_____

_____

_____

_____

_____

CALL 911 OR AN AMBULANCE IF:

_____

_____

_____

OVER FOR DAILY MANAGAMENT PLAN ⟶

Child's Name: _____

Be aware of the following asthma triggers:

_____

_____

Severe Allergies:

_____

_____

MEDICATIONS TO BE GIVEN AT SCHOOL:

Name of Medicine Dosage When to use

_____

_____

_____

Side effects to be reports to health care provider: _____

_____

☐ This child has exercise induced asthma and uses an inhaler before engaging in physical exercise.

☐ This child has exercise induced asthma and uses an inhaler during physical activity if wheezing.

Activity Restrictions: (example: staying indoors for recess, limited activity during physical education, etc.)

_____

_____

Please check all that apply:

☐ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child **should be allowed to carry and use** this medication by him or herself (*option available only to middle and high school students).*

☐ It is my professional opinion that this child **should not carry their own medications** (either inhaler or epi-pen).

☐ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or epi-pen.

☐ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is:_____.

Doctor's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____