# 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:** |
| | | |
| | | |
| | | |
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**SCHOOL MANAGEMENT OF ASTHMA:**

| **GREEN ZONE- GOOD** | **YELLOW ZONE- CAUTION** | **RED ZONE-DANGER** |
|---|---|---|
| **If student has ALL of these:**<br>• **Breathing is easy**<br>• **No Cough or wheeze**<br>• **Can play and work**<br><br>**NO TREATMENT NEEDED**<br><br>**If in GREEN ZONE BUT <u>EXERCISE</u> MAY CAUSE ASTHMA SYMPTOMS, USE:**<br><br>Use_____<br>**(name of medication)**<br>_____ puffs<br>_____ minutes before exercise | **If student has ANY of these:**<br>• **First sign of a cold**<br>• **Cough or mild wheeze**<br>• **Tight chest**<br>• **Problems with work or play**<br><br>□ **Use _____,**<br>**(name of medication)**<br>**_____ puffs inhaler every _____ hours as needed**<br><br>**OR**<br><br>□ **Use _____,**<br>**(name of medication)**<br>**_____ nebulizer treatment every _____ hours as needed**<br><br>□ **Other treatment needed:**<br>_____<br>_____ | **If student has ANY of these:**<br>• **Can't talk, eat, or walk well**<br>• **Medicine is not working**<br>• **Breathing hard and fast**<br>• **Blue lips and fingernails**<br>• **Tired or lethargic**<br>• **Skin around neck and ribs pulls in**<br><br>**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

Information about students and family is strictly confidential and all efforts to maintain this are very important.

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