ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

ASTHMA MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

Name: _____ Grade: _____ Date of Birth: _____

Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (H) _____
Address: _____ (W) _____
_____ (C) _____

Parent/Guardian Name: _____ Ph:(H) _____
Address: _____ (W) _____
_____ (C) _____

Place ID Photo Here

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Asthma Healthcare Provider: _____ Phone: _____

Other Healthcare Provider: _____ Phone: _____

Daily Asthma Management Plan

· Identify the things that start an asthma episode (check all that apply to the student)

[ ] Exercise
[ ] Chalk Dust
[ ] Animals
[ ] Molds
[ ] Strong odors or fumes
[ ] Change in temperature
[ ] Pollens
[ ] Other _____
[ ] Respiratory Infections
[ ] Carpets in the room
[ ] Food _____

Comments: _____

·Control of School Environment

(List any environmental control measures, pre-medications and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____

_____

·Peak Flow Monitoring

Personal best peak flow number: _____ Monitoring Times: _____ _____ _____

·Daily Medication Plan

	Name	Amount/Dose	When to Use
1.			
2.			
3.			
4.			

 Revised July, 2011

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

_____

or has a peak flow reading of _____

- Steps to take during an asthma episode:
  1. Give medications as listed below.
  2. Have student return to classroom if _____
     _____
  3. Contact parent if _____
     _____
  4. Seek Emergency Medical Care if the student has any of the following:
     No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
     Peak Flow of _____
     Hard time breathing when:
     Chest and neck pulled in with breathing
     Child is hunched over
     Child is struggling to breathe
     Trouble walking or talking
     Stops playing and cannot start activity again
     Lips or fingernails are gray or blue

- **Emergency Asthma Medications**

	Name	Amount/Dose	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments / Special Instructions

_____

_____

_____

For Inhaled Medications

[ ] I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

[ ] It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ _____

Physician's Signature Date

_____ _____

Parent's Signature Date