Medical Management Plan SCHOOL YEAR 2019-2020

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Stu	udent Name:	Da	Date of Birth:					
Ph	ysician's Name:		Phone #:					
Ad	ldress:		Fay #·					
Lis	t Known ALLERGIES:							
Ide	entify the things that start an as	thma episode (check all that apply to	the student)					
	Exercise	Strong odors of fumes	Respiratory infections					
	Chalk Dust	Change in temperature	Carpets in the room					
	Animals	Pollens	Food					
	Molds	Other						
Da	aily Medication Plan							
	Name of Medication	Amount/Dose	When to use					
1.								
2.								
3.								
EN	TERGENCY ACTION is necessary	when the student has symptoms such	h as:					
	Steps to take during an asthma episode: Give emergency medications listed below. Seek Emergency Medical							
	-							
Ca	re if the student has any of the	following: No improvement 15-20 m	ninutes after initial treatment with					
Ca me	re if the student has any of the edication, and a relative cannot	following: No improvement 15-20 m be reached. Continued difficulty bre	ninutes after initial treatment with eathing. Trouble walking or talking. Stops					
Ca me	re if the student has any of the edication, and a relative cannot	following: No improvement 15-20 m	ninutes after initial treatment with eathing. Trouble walking or talking. Stops					
Car me pla	re if the student has any of the edication, and a relative cannot aying and cannot start activity a	following: No improvement 15-20 m be reached. Continued difficulty bre gain. Lips or fingernails are gray or bl	ninutes after initial treatment with eathing. Trouble walking or talking. Stops					
Car me pla	re if the student has any of the edication, and a relative cannot aying and cannot start activity a mergency Asthma Medication	following: No improvement 15-20 m be reached. Continued difficulty bre gain. Lips or fingernails are gray or bl	ninutes after initial treatment with eathing. Trouble walking or talking. Stops llue.					
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Continued Asthma Plan for (Student NAME)		
Is your child compliant with their current treatment of Does your child function independently with medical Are there any activity restrictions for your child?		Yes No No Yes No No No
PARENT to Complete: Authorization for Information I authorize my child's school nurse to assess my child as with my child's physician as needed throughout the school plan for my child. I understand I may withdraw this author As the parent or guardian of the student named above, I red of medication/treatment prescribed for my child. I understand that under provisions of Florida Statue 10 administration of medication when the person administration would have acted under the same or similar circumstance listed above if there are any questions or concerns about the same or similar circumstance.	it relates to his/her special health care of year. I understand this is for the rization at any time and that this authequest that the principal or principal's 06.062, there shall be no liability for ating such medication acts as an order. I also grant permission for schoothe medication. I have read the guide	e needs and to discuss these needs ourpose of generating a health care orization must be renewed annually. designee assist in the administration or civil damages as a result of the dinarily reasonable, prudent person personnel to contact the physician
authorize the physician to release information about this co	Print Name	Date
Parent/Guardian:	Cell:	
Parent/Guardian:	Work: Cell:	
	Work:	