Medical Management Plan ASTHMA
SCHOOL YEAR 2024-2025

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Identify the things that start an asthma 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 _____	

Daily Medication Plan

Name of Medication	Amount/Dose	When to use
1.		
2.		
3.		

EMERGENCY ACTION is necessary when the student has symptoms such as:

_____

***Steps to take during an asthma episode*: Give emergency medications listed below. 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. Continued difficulty breathing. 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.		

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20

Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physician.

The above named child may carry and self-administer his/her metered dose inhaler**.**

Parent/Guardian Signature: (Required) _____ **Date:** _____

Physician's Signature: (Required) _____ **Date:** _____

Continued Asthma Plan for (Student NAME) _____

Is your child compliant with their current treatment regime?	Yes		No	
Does your child function independently with medication administration?	Yes		No	
Are there any activity restrictions for your child?	Yes		No	

If yes, please list: _____

PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	**Print Name**	**Date**

Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____