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
- [ ] Chalk Dust
- [ ] Animals
- [ ] Molds
- [ ] Strong odors of fumes
- [ ] Change in temperature
- [ ] Pollens
- [ ] Other ______________________
- [ ] Respiratory infections
- [ ] Carpets in the room
- [ ] Food

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: ______________________