# Medical Management Plan ASTHMA
## SCHOOL YEAR 2023-2024

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: _____