

# SCHOOL-BASED ASTHMA MANAGEMENT PLAN

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health. This form expires on June 30, \_\_\_\_\_

## STUDENT INFORMATION

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_

Physical Education Days and Times: \_\_\_\_\_

## EMERGENCY INFORMATION

### TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN:

Parent/Guardian Name(s): \_\_\_\_\_  
\_\_\_\_\_

First Priority Contact: Name \_\_\_\_\_  
Phone \_\_\_\_\_

Second Priority Contact: Name \_\_\_\_\_  
Phone \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### TO BE COMPLETED BY THE CHILD'S DOCTOR:

#### WHAT TO DO IN AN ACUTE ASTHMA EPISODE:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**CALL 911 OR AN AMBULANCE IF:** Review attached "Signs of an Asthma Emergency and list any additional symptoms the child may present with:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Daily Management Plan – To be completed by the child's doctor.  
OVER FOR DAILY MANAGEMENT PLAN

Administration of Medications

Child's Name: \_\_\_\_\_

Be aware of the following asthma triggers:

\_\_\_\_\_

Severe Allergies:

\_\_\_\_\_

**MEDICATIONS TO BE GIVEN AT SCHOOL:**

NAME OF MEDICINE	DOSAGE	WHEN TO USE

Side effects to be reported to health care provider:

\_\_\_\_\_

Does this child have exercise-induced asthma? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

This child uses an inhaler before engaging in physical exercise and if wheezing during physical activity. Yes \_\_\_\_\_ No \_\_\_\_\_

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education):

\_\_\_\_\_  
\_\_\_\_\_

Please check all that apply:

\_\_\_\_\_ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use that medication by him/herself.

\_\_\_\_\_ It is my professional opinion that this child should not carry his/her inhaled medications or epi-pen by him/herself.

\_\_\_\_\_ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or epi-pen.

\_\_\_\_\_ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: \_\_\_\_\_.

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_