

SURRY COUNTY SCHOOLS
SCHOOL HEALTH PROGRAM

Asthma Medical Management Plan
School Year _____

Name of Student _____ Date of Birth _____

School _____ Grade/Teacher _____

Parent/Guardian _____ Phone _____

_____ Phone _____

Physician _____ Phone _____ Hospital _____

1. How often does the child have an asthma attack? _____
2. Medications At Home: _____
Medications at School: _____ Location: _____
3. Side effects from these medications: _____
4. Activities/exercise restrictions: _____

Identify the things which start an asthma episode (known as triggers.)
Check each that applies to your child.

<input type="checkbox"/> Exercise	<input type="checkbox"/> Smoke, strong odors or spray
<input type="checkbox"/> Mold	<input type="checkbox"/> Colds/Respiratory infections
<input type="checkbox"/> Chalk dust/dust	<input type="checkbox"/> Carpet
<input type="checkbox"/> Pollen	<input type="checkbox"/> Change in temperature
<input type="checkbox"/> Animals	<input type="checkbox"/> Dust mites
<input type="checkbox"/> Tobacco smoke	<input type="checkbox"/> Cockroaches
<input type="checkbox"/> Food _____	<input type="checkbox"/> Other _____

The following are signs and symptoms that need immediate attention:

Coughing	Pale
Shortness of breath	Anxious face
Wheezing	Bluish nail beds and lips
Whistling sounds	Perspiring
Gasping voice	Flaring of nostrils

Interventions:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by health care provider.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficulty or if medication is not effective.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to _____ Hospital.
8. Additional instructions: _____

Student Responsibilities if Authorized to Self-administer Medication:

1. I will keep my medication/equipment with me at all times.
2. I agree to use my equipment and take my medication according to my Medical Management Plan.
3. I will notify my teacher or someone in the office if I am having more difficulty than usual with my health condition.
4. I will not allow any other person to use my equipment or take my medication.
5. I understand that the school will **not** be responsible for my equipment or medication. The condition and accuracy of it as well as the frequency of use is my responsibility.
6. It is my (and my parents) responsibility to notify the school of changes in my health status or in the use of my equipment or medication.

STUDENT SIGNATURE _____ Date _____

PARENT/GUARDIAN SIGNATURE _____ Date _____

SCHOOL NURSE SIGNATURE _____ Date _____

HEALTH CARE PROVIDER SIGNATURE _____ Date _____

Revised: 3-11-2012