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| **Medical Management Plan** | | **ASTHMA** |
| **SCHOOL YEAR** | **2025-2026** | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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.** |  |  |

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| **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.** |  |  |

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| *Nursing services are recommended for the care of this student during the school day.* | | | |
| **Physicians Signature:** |  | **Date:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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:** |  | |  |  |  |  | |

|  |  |
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| **Continued Asthma Plan for (Student NAME)** |  |

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| --- | --- | --- | --- | --- | --- |
| 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: |  |