

SCHOOL-BASED ASTHMA MANAGEMENT PLAN

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

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:

DAILY MANAGEMENT PLAN - TO BE COMPLETED BY THE CHILD'S DOCTOR.

OVER FOR DAILY MANAGEMENT PLAN →

AUTHORIZATION FOR MEDICATION

Dear Parent and Physician,

It is the policy of the Tri-County Area Schools to have written authorization for a student taking prescribed oral medication during the school day. This information will be handled in a confidential manner.

Parent, please complete the following section:

Student Name _____ Birth date _____

I hereby advise school personnel that the above-named student is taking the following prescribed oral medication, during school hours, according to the physician's directions and agree that the School District shall not be held responsible for administering the medication.

Parent's Signature _____ Date _____

Physician, please complete:

Student's Name _____

Name of Medication _____

Dosage _____

Time _____

For Period _____ to _____
(date) (date)

Reason for Medication (Diagnosis, Anticipated Effects): _____

Possible Reactions or Symptoms: _____

Additional Comments: _____

Physician's Signature _____ Date _____

Address _____ Telephone _____

This authorization must be renewed annually and/or when a modification of the original request takes place.