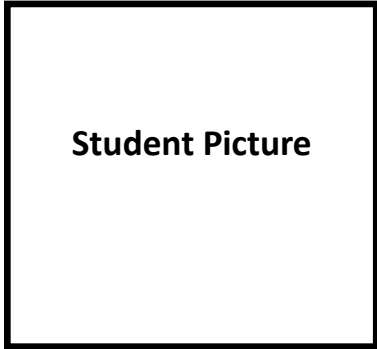




# Breathing Management Health Plan

School Year: \_\_\_\_\_

**\*\*Expires at end of current school year\*\***



**Student Picture**

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade/Teacher/House: \_\_\_\_\_

Medical Practitioner Providing Care: \_\_\_\_\_

Provider Phone: (\_\_\_\_) \_\_\_\_\_ Provider Fax: (\_\_\_\_) \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Breathing management medication to be given at school, always use a spacer with your inhaler as directed:**

**To be completed by Medical Practitioner**

Medication	Time/Frequency	Dosage	Route	Reason for Administer

**Inhaler Storage:**

Inhaler will be kept in health room.

Yes, this patient has received instruction and has demonstrated competency in the use of a metered dose inhaler. He/She may carry and self administer the inhaler as prescribed during the school day, on field trips and after school activities.

Medical Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give consent for school personnel to administer the above listed medications. I agree to notify the school in writing when any changes in the above order is necessary. I understand that all unused medication will not be returned to my student unless authorized to self-carry. It will be my responsibility to come to the health room to collect the unused medication at the end of the school year.

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