DAILY TREATMENT PLAN

Please list any medications taken daily to manage asthma, including nebulizer treatments.

	Name	***Purpose***	***Dosage***	***When to use***
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

These medications are prescribed for the time period _____until_____.

Medical Equipment:

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, oxygen, etc.)

_____

_____

Emergency action is necessary when this student has symptoms such as:

1. _____ 3. _____
2. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick-relief medication):

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Can be repeated for severe breathing difficulty _____times_____minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other medications

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Additional instructions: _____

These medications are prescribed for the time period_____until_____.

2. Seek emergency medical care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
- Student exhibits any of the following behaviors:

chest and neck pulled in with breathing
trouble walking or talking
stops playing and cannot start activity again
struggling to breathe
hunched over while breathing
lips or fingernails turn gray or blue

Comments and special instructions: _____

_____

_____

_____ _____

Physician's signature **Date**

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

_____ _____

Parent/Guardian's signature **Date**