

WYANDOTTE PUBLIC SCHOOLS

School-Based Asthma Management Plan

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ School Year: \_\_\_\_\_

EMERGENCY INFORMATION: TO BE COMPLETED BY CHILD'S PARENT/GUARDIAN:

Parent/Guardian names: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN:

What to do in an acute asthma episode:

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Call 911 for the following symptoms: \_\_\_\_\_

Be aware of the following asthma triggers: \_\_\_\_\_

Severe allergies: \_\_\_\_\_

If medications are to be taken at school, please complete attached Medication Authorization Form:

PLEASE CHECK ALL THAT APPLY:

- Has exercised induced asthma
Uses an inhaler before physical exercise
Uses an inhaler if wheezing occurs during physical activity

Activity Restrictions (e.g. staying indoors for recess, limited activity during physical education,):

PLEASE CHECK ALL THAT APPLY:

- I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use the medication by him/herself.
I have instructed this student in the proper way to use his/her inhaled medications. It is my professional opinion that this student should be allowed to carry and use the medication with supervision.
It is my professional opinion that this student should not be allowed to carry the medication by him/herself

Physicians signature: \_\_\_\_\_ Date: \_\_\_\_\_

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