WYANDOTTE PUBLIC SCHOOLS

School-Based Asthma Management Plan

Student Name: ____________________ DOB: ______________ School Year: ________

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

Parent/Guardian names: __________________________ Home Phone: ________________
Cell Phone: ________________

(1.) Emergency Contact Name: _____________________ 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 given 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.
____ It is my professional opinion that the child **should not carry** his/her inhaled medications by him/herself
____ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: ____________.

Physicians signature: ______________________________ Date: ______________

Parent/Guardian Signature: ______________________________ Date: ______________