

WYANDOTTE PUBLIC SCHOOLS

School-Based Asthma Management Plan

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

EMERGENCY INFORMATION: 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: \_\_\_\_\_