



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:

Medication	Strength & Dose i.e. 90 mcg - 2 puffs	Route	Time/Frequency	Reason for Administration

Inhaler Storage:

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Inhaler will be kept in health room.

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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: _____