Elmbrook Schools
become what's next

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: (_____) _____

To be completed by Medical Practitioner

Diagnosis: _____

Breathing management medication to be given at school, always use a spacer with your inhaler as directed:

Medication	Dose & Amount i.e. 90 mcg - 2 puffs	Frequency	Route	Reason for Administer

Inhaler Storage:

☐ Inahler will be kept in health room.

☐ 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: _____