Clinic Use LOCATION OF EMERGENCY MEDICATION AT SCHOOL: _____Self-Carry □ Location: _____

GWINNETT COUNTY PUBLIC SCHOOLS
HEALTH AND SOCIAL SERVICES

ASTHMA
Health Management Plan
SCHOOL YEAR_____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

Parent/Guardian	**Parent/Guardian**
Phone:	**Phone:**
Phone:	**Phone:**
Emergency Contact:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

Medication Name (include those taken at home):	**Dose:**	**Time:**

SCHOOL MANAGEMENT OF ASTHMA:

GREEN ZONE- GOOD

If student has ALL of these:

- Breathing is easy
- No Cough or wheeze
- Can play and work

NO TREATMENT NEEDED

****If medication is required before EXERCISE****

□ Use_____
(name of medication)
_____ puffs
_____ minutes
before exercise.

YELLOW ZONE- CAUTION

If student has ANY of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems with work or play

□ Use _____,
(name of medication)
_____ puffs inhaler every _____ hours as needed.

OR

□ Use _____,
(name of medication)
_____ nebulizer treatment every _____ hours as needed.

RED ZONE-DANGER

If student has ANY of these:

- Can't talk, eat, or walk well
- Medicine is not working
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Skin around neck and ribs pulls in

Call 911 then contact parent.

This section is to be completed by a Physician IF student is to possess and self-administer medication in school, at a school sponsored activity; while under the supervision of school personnel; or before, during, or after school care on school operated property, (in compliance with SB 472, effective 7/01/02).

FOR INHALED MEDICATIONS: *(Please check one of the options below)*

1. _____I have instructed this student in the proper use and dosage of the inhaled medication. It is my opinion that this student may carry and self-administer the inhaled asthma medication.
2. _____This student in NOT approved to self-administer the inhaled asthma medication.

_____ _____
Physician Signature Date

School Clinic: Copy of this plan should be provided to Transportation Supervisor.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE CLUSTER NURSE SIGNATURE DATE

Information about students and family is strictly confidential.

Rev. 2/2024