

Asthma Management Plan
Northville Public Schools
School Year; _____

Please
provide your
child's photo
here

Student's Name: _____ Birthdate: _____

School: _____ Teacher: _____ Grade: _____

Physician/Licensed Prescriber:

Diagnosis: _____

Medication Name: Metered Dose Inhaler (MDI) Albuterol or _____

Dose/Frequency: 2 puffs every 4 hours as needed for symptoms or _____

Child should use a spacer device with inhaler Yes No

Child is able to self-administer medication and should be allowed to carry inhaler Yes No
(If child will be carrying inhaler, back up inhaler should be kept in the school office/clinic)

- ✓ Inhaler will be kept in: school office/clinic _____ backpack _____ desk _____ other _____
✓ Inhaler must accompany student on all field trips

Directions for use:

- Shake well
- Insert inhaler mouthpiece into spacer (if provided)
- Position as instructed by health care provider
- Press down on the inhaler to release the medication. Have child breathe in slowly and deeply. This is a puff.
- Have child hold their breath for 10 seconds to allow medication to stay in the lungs
- Wait for 1 minute, administer 2nd puff.
- Child should respond to treatment within 5-10 minutes
- If **no** change or breathing becomes worse, contact parent immediately
- If parent not available, or child's condition worsens, call 911

Physician's Signature Date Phone Number

Physician's Name (Printed) FAX Number

Parent/Guardian:

I request and give permission for my child _____ to receive this medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. The school requires parent/guardian to bring medication in its original container. All medication must be labeled with the student's name.

Parent/Guardian Signature Date

Phone Number Emergency Phone Number

To be completed by student:

I agree to: Never share my medication with another person. Take medication only as prescribed by my doctor. Carry the medication in its original properly labeled prescriptive or over-the-counter container. I am knowledgeable regarding the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and the privilege(s) of self-administration/self-possession denied.

Student's Signature Date