

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES
ASTHMA MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

Place
ID Photo
Here

Name: _____ Grade: _____ Date of Birth: _____

Teacher: _____ Room: _____

Asthma Healthcare Provider: _____ Phone: _____

Daily Asthma Management Plan

· Identify the things that start an asthma episode (check all that apply to the student)

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Chalk Dust | <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Molds | <input type="checkbox"/> Other _____ | |

Comments: _____

Daily Medication Plan

Name of Medication	Amount/Dose	When to use
1.		
2.		
3.		

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

Steps to take during an asthma episode: Give emergency medications listed below. Seek Emergency Medical Care if the student has any of the following: No improvement 15-20 minutes after initial treatment with medication, and a relative cannot be reached. Continued difficulty breathing. Trouble walking or Talking. Stops playing and cannot start activity again. Lips or fingernails are gray or blue.

Emergency Asthma Medications

Name	Amount/Dose	When to use
1.		
2.		
3.		

Comments / Special Instructions: _____

Physician's Signature _____ Date _____

ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20
 Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physician.
 The above named child may carry and self-administer his/her metered dose inhaler.

Parent/Guardian Signature: _____ Date: _____

Physician's Signature: (required) _____ Date: _____

Nursing services are recommended for the care of this student during the school day.

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature

Work/Home/Cell Phone

Date

Parent/Guardian Ph: (C) _____ (W) _____ (H) _____

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Emergency Contact Ph: (C) _____ (W) _____ (H) _____