ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

ASTHMA MEDICAL MANAGEMENT PLAN
SCHOOL YEAR 2016-2017

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)

[ ] Exercise
[ ] Strong odors or fumes
[ ] Respiratory Infections
[ ] Chalk Dust
[ ] Change in temperature
[ ] Carpets in the room
[ ] Animals
[ ] Pollens
[ ] Food ________________________________
[ ] Molds
[ ] 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 Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating 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**

__________________________ **Ph: (C)** _______________ **(W)** ________________ **(H)** ______________
Parent/Guardian

__________________________ **Ph: (C)**_______________ **(W)** ________________ **(H)** ______________
Parent/Guardian

__________________________ **Ph: (C)**_______________ **(W)**_________________ **(H)** ______________
Emergency Contact