

# Medical Management Plan

## SCHOOL YEAR 2024-2025

# ASTHMA

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

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

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors of 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 _____	

### Daily Medication Plan

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

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.		

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

Physicians 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: \_\_\_\_\_  
(Required)

Physician's Signature: (Required) \_\_\_\_\_ Date: \_\_\_\_\_

**Continued Asthma Plan for (Student NAME)** \_\_\_\_\_

Is your child compliant with their current treatment regime?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please list: \_\_\_\_\_

**PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information**

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. 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**

**Print Name**

**Date**

Parent/Guardian: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_