SUWANNEE COUNTY SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

ASTHMA MEDICAL MANAGEMENT PLAN

(Must be filled out completely by Physician/Healthcare Provider)

Student Name: _____ DOB: _____

School Year: _____ Allergies: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

DAILY ASTHMA MANAGEMENT

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Triggers: ☐ Animals ☐ Change in temperature ☐ Molds ☐ Strong Odor or Fumes ☐ Carpets ☐ Exercise
☐ Pollens ☐ Unknown ☐ Food _____ ☐ Other _____

Authorization form must be filled out by physician for medication use at school

Medication/Treatments at School: _____

Medication Plan at School: ☐ PRN only ☐ Prior to exercise ☐ Other _____

Restrictions at School: _____

Location of Rescue Inhaler: ☐ School Nurse in Clinic ☐ Carried by Student Student may self-administer: ☐ Yes ☐ No

EMERGENCY ASTHMA MANAGEMENT PLAN

- Emergency Action is necessary when the student has symptoms of respiratory distress.
- Give emergency medication as ordered above. Other _____
  If no improvement within 10 minutes ☐ **Call 911** ☐ repeat dose ☐ call parent
- Student may return to class if responds well to treatment.

Comments: _____

_____ _____
Physician/Provider Signature (Required) Date

_____ _____
Parent/Guardian Signature (Required) Date

_____ _____
School Nurse Signature Date