Muskegon Catholic Central School

School-Based Asthma Management Plan

(To be completed by the Student's Parent/Guardian)

Child's Personal Information

Child's Name: _____

Grade: _____ Date of Birth: _____

Emergency Information

Parent/Guardian Name(s):

_____ Phone # _____

_____ Phone # _____

Primary Emergency Contact:

_____ Phone # _____

Secondary Emergency Contact:

_____ Phone # _____

Doctor's Name: _____

Office Phone: _____

To Be Completed By The Child's Physician

What To Do In An Acute Asthma Episode

1. _____
2. _____
3. _____

When to Call 911/Ambulance (list the additional symptoms the student may present)

1. _____
2. _____
3. _____

Daily Management Asthma Plan – Completed by the Child's Physician on Reverse Side

Daily Management Asthma Plan

Child's Name: _____

Asthma Triggers:

_____ _____

_____ _____

Allergies:

_____ _____

Medications To Be Dispensed At School:

Name of Medicine	Dosage	When To Use

Possible Side Effect To Be Report To The Child's Physician:

_____ _____

_____ _____

Does Student Have Exercise-Induced Asthma? Yes _____ No _____

This Student Uses An Inhaler Before Engaging In Physical Exercise And If Wheezing During Physical Activity: Yes _____ No_____

Activity Restrictions: (if applicable:

_____ _____

Please Check ALL That Apply:

_____ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that this student should NOT carry his/her inhaled medications or Eigen by him or herself.

_____ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or EpiPen

_____ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: _____

Doctor's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____