CLAY COUNTY SCHOOL DISTRICT
FLORIDA DEPARTMENT OF HEALTH - CLAY COUNTY
SCHOOL HEALTH SERVICES
2016-2017

ASTHMA MEDICAL MANAGEMENT PLAN

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

Student Name: _____ DOB: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

Allergies: _____

DAILY ASTHMA MANAGEMENT

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

Triggers:

☐ Animals ☐ Carpets ☐ Chalk Dust ☐ Change in Temperature ☐ Cold/Flu ☐ Dust
☐ Exercise ☐ Mold ☐ Pollen ☐ Smoke ☐ Strong Odor or Fumes
☐ Food _____ ☐ Other _____

Restrictions at School: _____

For treatment of asthma symptoms, give:

Name of medication: _____

Directions for use: _____

If pre-medication is needed prior to exercise, specify directions: _____

_____

Location of Rescue Inhaler: ☐ School Nurse in Health Room ☐ Carried by Student ☐ Kept with Teacher/Staff

Student may self-administer: ☐ Yes ☐ No

***Medications must go with student if he/she is off school grounds (i.e. band or field trips, sporting events, etc.) ***

Equipment (to be supplied by parent):

☐ Mask ☐ Nebulizer Machine ☐ Spacer ☐ Mouthpiece ☐ Peak Flow Meter
☐ Tubing ☐ Other _____

EMERGENCY ASTHMA MANAGEMENT PLAN

- Emergency Action is necessary when the student has symptoms of respiratory distress.
- Emergency medication to be given as follows: _____

  If no improvement in 15 minutes: ☐ **Call 911** ☐ Repeat dose ☐ Call parent
- Student may return to class if _____

_____ _____
Physician/Provider Signature (Required) **Date**

_____ _____
School Nurse Signature **Date**

Office Stamp

OPJH Clinic Fax
904-278-2009

Revised 4/2016