



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**

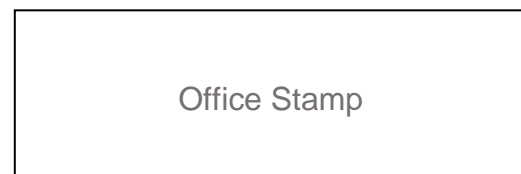
- o Emergency Action is necessary when the student has symptoms of respiratory distress.
- o Emergency medication to be given as follows: \_\_\_\_\_  
 If no improvement in 15 minutes:  Call 911  Repeat dose  Call parent
- o Student may return to class if \_\_\_\_\_

\_\_\_\_\_  
 Physician/Provider Signature (Required)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 School Nurse Signature

\_\_\_\_\_  
 Date



**OPJH Clinic Fax  
 904-278-2009**