SCHOOL-BASED ASTHMA MANAGEMENT PLAN
Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

STUDENT INFORMATION
Child’s Name: _________________________________________ Birth Date: _____________
Grade:___________ Home Room Teacher: ________________________________________
Physical Education Days and Times: _____________________________________________

EMERGENCY INFORMATION

TO BE COMPLETED BY THE CHILD’S PARENT/GUARDIAN:

Parent/Guardian Name(s): _____________________________________________
First Priority Contact: Name _____________________________________________
                Phone _____________________________________________
Second Priority Contact: Name _____________________________________________
                Phone _____________________________________________
Doctor’s Name: ____________________________________   Phone: __________________

TO BE COMPLETED BY THE CHILD’S DOCTOR:
WHAT TO DO IN AN ACUTE ASTHMA EPISODE:
1.                                            
2.                                            
3.                                            

CALL 911 OR AN AMBULANCE IF: Review attached “Signs of an Asthma Emergency”
and list any additional symptoms the child may present with:

DAILY MANAGEMENT PLAN - TO BE COMPLETED BY THE CHILD’S DOCTOR.
Child’s Name: _____________________

Be aware of the following asthma triggers: ___________________________________________
______________________________________________________________________________

Severe Allergies: _______________________________________________________________

MEDICATIONS TO BE GIVEN AT SCHOOL:

<table>
<thead>
<tr>
<th>NAME OF MEDICINE</th>
<th>DOSAGE</th>
<th>WHEN TO USE</th>
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Side effects to be reported to health care provider: __________________________________
______________________________________________________________________________

Does this child have exercise-induced asthma?  Yes  No
G  This child uses an inhaler before engaging in physical exercise and if wheezing during
physical activity.

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education):
___________________________________________________________________________
___________________________________________________________________________

Please check all that apply:

G  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.

G  It is my professional opinion that this child **should not** carry his/her inhaled medications or
epi-pen by him/herself.

G  Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler,
and/or epi-pen.

G  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’s Signature(s): __________________________________ Date: __________
__________________________________ Date: __________