School-Based Asthma Management Plan

This information expires on June 30, _____

Student Information

Student's Name: _____ Birth Date: _____

Grade: _____ Teacher / Classroom: _____

Physical Education Days and Times: _____

Emergency Information **To Be Completed by Student's Parent / Guardian**

Parent / Guardian Name(s) _____

_____

First Priority Contact: Name _____
Phone _____

Second Priority Contact: Name _____
Phone _____

Physician's Name: _____ Phone: _____

To be Completed by Student's Physician

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 Student's Physician