

ST. JOHNS COUNTY SCHOOL DISTRICT  
HEALTH SERVICES  
**ASTHMA MEDICAL MANAGEMENT PLAN**  
**SCHOOL YEAR 2016-2017**

Plac
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Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Asthma Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

**Daily Asthma Management Plan**

· Identify the things that start an asthma episode (check all that apply to the student)

- |                                     |  |   |
|-------------------------------------|--|---|
| <input type="checkbox"/> Exercise   | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Respiratory Infections |
| <input type="checkbox"/> Chalk Dust | <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room    |
| <input type="checkbox"/> Animals    | <input type="checkbox"/> Pollens               | <input type="checkbox"/> Food _____             |
| <input type="checkbox"/> Molds      | <input type="checkbox"/> Other _____           |   |

Comments: \_\_\_\_\_

**Daily Medication Plan**

Name of Medication	Amount/Dose	When to use
1.		
2.		
3.		

**Emergency Plan**

Emergency action is necessary when the student has symptoms such as:

\_\_\_\_\_

**Steps to take during an asthma episode:** Give emergency medications listed below. Seek Emergency Medical Care if the student has any of the following: No improvement 15-20 minutes after initial treatment with medication, and a relative cannot be reached. Continued difficulty breathing. Trouble walking or Talking. Stops playing and cannot start activity again. Lips or fingernails are gray or blue.

**Emergency Asthma Medications**

Name	Amount/Dose	When to use
1.		
2.		
3.		

Comments / Special Instructions: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20**  
 Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physician.  
 The above named child may carry and self-administer his/her metered dose inhaler.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: (required) \_\_\_\_\_ Date: \_\_\_\_\_

*Nursing services are recommended for the care of this student during the school day.*

**THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:**

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

I authorize the physician to release information about this condition to school personnel.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Work/Home/Cell Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Ph: (C) \_\_\_\_\_ (W) \_\_\_\_\_ (H) \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Ph: (C) \_\_\_\_\_ (W) \_\_\_\_\_ (H) \_\_\_\_\_

\_\_\_\_\_  
Emergency Contact Ph: (C) \_\_\_\_\_ (W) \_\_\_\_\_ (H) \_\_\_\_\_