Middleton-Cross Plains Area School District

Asthma Medical Management Plan

Plan to be completed by a parent/guardian and health care provider

Student Name: _____ **DOB** _____ **Grade** _____

Asthma Triggers: _____

Asthma Episode Signs / Symptoms: shortness of breath / wheezing / coughing / chest tightness

Other signs / symptoms: _____

Medicine	Dose	Route	Frequency	Duration	Side Effects to report to Physician

Medication / Inhaler will be kept in the Health Office? **( )** Yes **( )** No

Will the Student self-carry an inhaler? **( )** Yes **( )** No

The student has been instructed on proper use of and is permitted to self-carry the inhaler and/or medication.

( ) Yes **( )** No

_____ _____

Physician's Signature Date

_____ _____

Physician's Phone Physician's Fax

I hereby give permission to the school nurse or delegate to contact the physician in regard to this plan. I understand it is my responsibility to notify the school of changes to this plan and will provide new medical orders at that time. I also consent to the release of information contained in this plan to staff members who may be supervising my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Phone Alternate Phone

Other Emergency Contact: _____

_____ _____ _____

Relationship to child Phone Alternate Phone

**********Office Use Only**********

_____ _____

School Nurse's Signature Date

_____ _____

Health Assistant's Signature Date

Health Office Notes:

_____

_____