Woodhaven-Brownstown School District
Special Services Department
22650 Sibley Road
Brownstown, Mi 48193
Phone: 734-783-3322
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This information expires on June 30, _____

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:

Consider "Signs of an Asthma Emergency" and list any symptoms the child may present with:

1. _____
2. _____
3. _____

Daily Management Plan – To be completed by the child's doctor.

OVER FOR DAILY MANAGEMENT PLAN

Child's Name: _____

Be aware of the following asthma triggers:

_____

_____

Severe Allergies: _____

_____

MEDICATIONS TO BE GIVEN AT SCHOOL

NAME OF MEDICINE	DOSAGE	WHEN TO USE

Side effects to be reported to health care provider:

_____

_____

Does this child have exercise-induced asthma? Yes _____ No _____

This child uses an inhaler before engaging in physical exercise and if wheezing during physical activity. Yes _____ No _____

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

_____

_____

Please check all that apply:

____ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that his child **should be allowed** to carry and use that medication by himself/herself.

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

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

____ 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: _____

Signed form indicates consent for physician staff and school staff to share information as needed to meet health needs of the student.