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.
OVER FOR DAILY MANAGEMENT PLAN →
Be aware of the following asthma triggers:

____________________________________________________________________________________

Severe Allergies: _______________________________________________________________

MEDICATIONS TO BE GIVEN AT SCHOOL:

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<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

☐ 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:

☐ 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.

☐ It is my professional opinion that this child **should not** carry his/her inhaled medications or epi-pen by him/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: __________