ASTHMA MANAGEMENT CARE PLAN

STUDENT NAME: _____ GRADE: _____

Parent/Guardian Name: _____ DAYTIME phone #:_____

What causes your asthma symptoms?

Is your asthma exercise induced? YES☐ NO☐

Do you use your inhaler prior to exercise? YES☐ NO☐ SOMETIMES☐

If sometimes when?

Do weather conditions affect your asthma? If so list them.

Do you, the student, understand asthma and how to manage it? Can you recognize the signs and symptoms of an asthma attack? Can you treat it? Please comment.

PEAK FLOW-Personal Best: _____

Asthma Medication

All prescription drugs being taken at school/athletics/camp require written physician's authorization

NAME	DOSAGE	TAKE AT HOME	TAKE AT SCHOOL	SIDE EFFECTS

_____

_____

_____

How do you want the school to treat an episode of asthma? Please be specific

_____

_____

Are you allowed to resume the activity if symptoms resolve? YES☐ NO☐

If you do not respond to medication, what action does the parent/guardian advise the school to take? (*911 will be called if the student requests or if in severe distress- struggling to breathe, lips blue, unable to walk, talk and the parent will be called*)

_____

_____

Comments: _____

Signature of Parent/Guardian: _____ DATE: _____

I understand my responsibilities in using an inhaler.

Signature of Student: _____ DATE: _____

If I self medicate using my inhaler I will inform my teacher and/or the school nurse.

Signature of Student: _____ NA: _____ DATE: _____

Scan & email completed forms to:
summer@laurelschool.org

OR

Fax completed forms to:
216-464-8996
Attention: Summer at Laurel

For additional assistance, please call 216-455-3065