Lubbock Christian School
Asthma Management Plan

Must be signed by parent and physician and updated yearly

STUDENT: _____ GRADE: _____ **EFFECTIVE DATE:**_____

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Asthma Triggers: (Check all that apply)

_____ Exercise _____Animals _____ Emotions/stress _____ Pollen
_____ Respiratory Illness _____ Smoke, fumes _____ Change in Temperature _____ Molds
_____ Carpets _____ Foods _____ _____ Other _____

Student's Daily Medications: (List all medications administered at home and at school, including nebulizer treatments)

_____ _____ _____
_____ _____ _____

I request that this Asthma Management Plan be implemented for my child according to the signed protocol below from my child's physician. I hereby give my permission for the school nurse to consult with the prescribing physician regarding these orders.

Parent/Guardian Signature _____ **Date** _____

Emergency Phone Number _____

TO BE COMPLETED BY PHYSICIAN

Emergency Action is needed when student has symptoms such as:

1._____ 2. _____ 3. _____ 4. _____

STEPS to take during an asthma episode:

Give emergency asthma medications: (Parents must provide to school)

Bronchodilator (Quick-relief medication):

Name: _____
Purpose: _____
Dosage: _____
When to Use: _____

**** Can be repeated for severe breathing difficulty** _____ times _____minutes apart

**** Call 911 if minimal or no improvement**

Other medications:

Name: _____
Purpose: _____
Dosage: _____
When to Use: _____

Additional Instructions: _____

PHYSICIAN AUTHORIZATION FOR ASTHMA SELF-CARE

_____ I have instructed this student in the procedure to use his/her asthma medication, and it is my professional opinion that this student SHOULD be allowed to carry and self-administer the medication as directed above, on a properly labeled container, at the times and dosages indicated above.

_____ It is my professional opinion that this student SHOULD NOT carry and self-administer his/her asthma medications while on school property or at school related events.

Printed Name of Physician: _____

Physician Signature: _____ Date: _____

Physician's Office Number: _____ FAX: _____