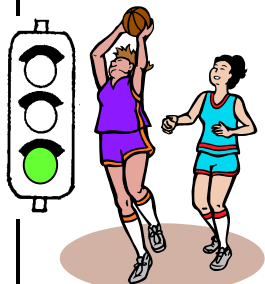


ASTHMA MANAGEMENT PLAN Patient Name _____ Date of Birth _____ Best Peak Flow _____ / _____

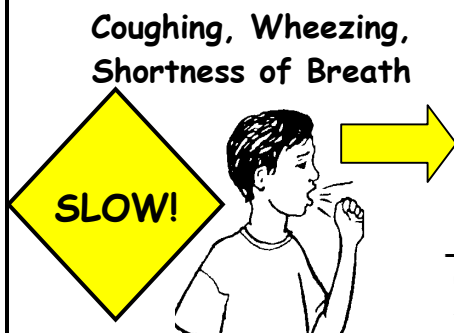
Health Center/Office _____ Phone Number _____ Provider Name _____



#	Medication	Dose	How to take?	When to take?
#1				
#2				
#3				

Which medications are ordered for the school nurse to give? Med.#1: time _____ Med.#2: time _____ Med.#3: time _____

Common side effects: _____



OR



Call the Health Center/Office
if there is no improvement!



Rescue Medication	Dose	How to take?	When to take?
Is rescue medication ordered for the school nurse to give PRN? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Peak Flow: _____ - _____

Anti-inflammatory	Dose	How to take?	When to take?



OR



Call Health Center/Office Now!
Call 911 if Condition Worsens!



**Extreme Trouble Breathing,
Cannot Walk or Talk!**

Peak Flow _____ - _____

Give Rescue Medication!

FOR SCHOOL OR AFTER SCHOOL PROGRAMS

I have instructed _____ in the proper way to use his/her medications.

In my professional opinion this child ☐ should ☐ should not be allowed to carry and use these medications.

Comments/Special Instructions _____

Physician signature _____ Parent/Gaurdian signature _____

Emergency parent/gaurdian phone # _____

Other Important Instructions:

1. No smoking in your home or car.
2. Remove known triggers from your child's environment:

