THE Independence SCHOOL

Inspire. Dream. Achieve.

ASTHMA MANAGEMENT PLAN

CHILD'S NAME ____________________________ **AGE** _____

Daily Medication Plan

	Name of medication	Amount given	Time given
1.	____________________	____________________	____________________
2.	____________________	____________________	____________________
3.	____________________	____________________	____________________

Please list any things that you know may **start an asthma episode:**

____

Please list any **symptoms** that would indicate your child is **having a problem:**

____

Please list child's **normal peak flow number:** ____________________

Emergency Procedures

If peak flow number falls below ________, please do the following: ______________________

List medication, dosage and indication for medication below:

Medication	Dosage	When to use
____________________	________	____________________
____________________	________	____________________
____________________	________	____________________

List medications kept at school:

____

Emergency Contacts

Name ____________________ **Relation to Child** ______________ **Phone** ______________

Name ____________________ **Relation to Child** ______________ **Phone** ______________

Doctor ____________________ **Phone** ______________

Parent/Guardian Signature ________________________ **Date** __________

Physician's Signature ________________________ **Date** __________

04/25/2018