Montgomery County School Health Services

ASTHMA IS MANAGEABLE

School Asthma Management Plan

Student Name _____ Birthdate _____ Today's Date _____

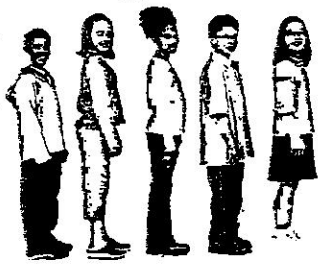
Parent Name _____ Health Care Provider _____

Dear Parent/Guardian,

Please complete and return this form to the Healthroom so that school and health staff can better assist your child manage his/her asthma. **All students who have medications for asthma management at school must have this form completed by a parent or guardian or have an asthma action plan completed by the health care provider.**

When my child has an asthma episode, he/she has the symptoms circled below:

Shortness of breath	Rapid breathing
Blue or gray lips	Anxiety/Panic
Coughing	Wheezing
Blue or gray finger tips	Dizziness
Other _____	



When my child has an asthma episode, it may be caused by the items circled below:

Smoke	Mold
Cockroaches	Stress/emotional upsets
Animals/pets	Strong smells/perfume
Dust/dustmites	Respiratory illness
Grass/flowers	Chalk/chalk dust

Weather changes/very cold or very hot air

Foods _____

My Child:

Is seen regularly by a health care provider to monitor asthma	Yes	No
Needs emergency medication two or more times per week	Yes	No
Wakes up at night coughing two or more times per month	Yes	No
Was seen in Emergency Room due to asthma in the past year	Yes	No
Was hospitalized due to asthma in the past year	Yes	No

My Child:

Uses a spacer with medication administered by an inhaler	Yes	No
Uses a peak flow meter to monitor his/her asthma	Yes	No

Has a normal peak flow reading of _____

Needs emergency medication when the peak flow reading is less than _____

Needs medical attention when the peak flow reading is less than _____

My child will need medication at school	Yes ☐	No ☐
Mi Hijo/a necesita medicina en la escuela	Si	No

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