Asthma Daily Treatment Plan

Name of Student: ______________________________ Date of Birth: ______________

Grade: ______________ Teacher: ______________________________

Please list any medications taken daily to manage asthma, including nebulizer treatments.

	Name of medication	Purpose	Dosage	When to use
1.				
2.				
3.				

These medications are prescribed for the time period from ______________ until ______________

Medical Equipment.

Please list any medical equipment this student will need to treat his/her asthma at school ***(i.e. spacer, nebulizer, oxygen, etc.)***

______________________________ ______________________________

______________________________ ______________________________

Steps to take during an asthma episode.

1. **Give emergency medications**

   Bronchodilator *(quick-relief medication)*

   ______________________________ ______________________________
   Name *Purpose*

   ______________________________ ______________________________
   Dosage *When to use*

   Can be repeated for severe breathing difficulty ________ times ______________ minutes apart.

   Call 911 or EMS if minimal or no improvement.

   Other medications

   ______________________________ ______________________________
   Name *Purpose*

   ______________________________ ______________________________
   Dosage *When to use*

   ____
   Additional instructions

2. **Seek emergency medical care if this student experiences any of the following:**
   - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - Student exhibits:

     Chest and neck pulled in with breathing
     Hunched over while breathing
     Struggling to breathe
     Trouble walking or talking
     Stops playing and cannot start activity again
     Lips or fingernails turn gray or blue

   ____
   Comments or special instructions

______________________________ ______________
Physician's signature *Date*

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with the physician's instructions above.

______________________________ ______________
Parent's/Guardian's signature *Date*