DAILY MANAGEMENT PLAN
To be completed by the child's physician

The following are possible signs of an asthma/allergic emergency

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingertips
- Failure of the medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The following steps need to be taken immediately:

- Call 911
- Call Parent/Guardian

Other information _____

_____

Medication to be given at school Dosage When to use

_____ _____ _____

_____ _____ _____

Side effects to be reported to the physician _____

Does this child have exercise-induced asthma? Yes _____ No _____

Activity restrictions _____

Please check all that apply:

_____ I have instructed this child in the proper way to use his/her inhaled medications/ Epi-pen. It's my professional opinion that _____ should be allowed to carry and use that medication by him/herself. Parent also authorizes self-medication.

_____ It is my professional opinion that _____ should not carry his/ her inhaled medications or Epi-pen by him/herself. Parent understands student may not carry medication.

_____ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or Epi-pen.

Physician's Signature _____ Date _____

Parent's Signature _____ Date _____

School Nurse Signature _____ Date _____

MEDICATION MUST BE CARRIED IN THE ORIGINAL CONTAINER WITH THE PHARMACY LABEL INTACT.

FREMONT PUBLIC SCHOOLS

School Asthma/Epi-pen Management Plan

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health.

This information expires on June 30, _____.

STUDENT INFORMATION

Child's name: _____ Birth date: _____

Grade: _____ Homeroom teacher: _____

Physical Education days and times: _____

EMERGENCY INFORMATION

Parent/Guardian Name(s): _____ Phone: _____

_____ Phone: _____

First Priority Contact: Name: _____ Phone: _____

Second Priority Contact: Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Severe allergies _____

Asthma triggers _____

List all current medications including those taken just at home.

_____

_____

_____

To be completed by the student:

I agree to: 1) never share my medication with another person, 2) carry the medication in it's original properly labeled container, 3) take the medication only at the prescribed time, frequency and dose, and 4) carry a copy of this form with me and present it to the school staff if asked. I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication. I understand that if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardians, and the privilege of self-administration/self-possession will be denied.

Student signature _____ Date _____