

# Asthma Management Plan

Northville Public Schools

School Year \_\_\_\_\_

Please  
provide your  
child's photo  
here

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Meads Mill Middle School \_\_\_\_\_ Grade: \_\_\_\_\_

## Physician/Licensed Prescriber:

Diagnosis: \_\_\_\_\_

Medication Name: Metered Dose Inhaler (MDI) Albuterol or \_\_\_\_\_

Dose/Frequency: 2 puffs every 4 hours as needed for symptoms or \_\_\_\_\_

Child should use a spacer device with inhaler Yes No

Child is able to self-administer medication and should be allowed to carry inhaler Yes No  
(If child will be carrying inhaler, back up inhaler should be kept in the school office/clinic)

✓ Inhaler will be kept in: school office/clinic \_\_\_\_\_ backpack \_\_\_\_\_ desk \_\_\_\_\_ other \_\_\_\_\_

## Directions for use:

- Shake well
- Insert inhaler mouthpiece into spacer (if provided)
- Position as instructed by health care provider
- Press down on the inhaler to release the medication and have child breathe in slowly and deeply. This is a puff.
- Have child hold their breath for 10 seconds to allow medication to stay in the lungs
- Wait for 1 minute, administer 2<sup>nd</sup> puff.
- Child should respond to treatment within 5-10 minutes
- If **no** change or breathing becomes worse, contact parent immediately
- If parent not available, or child's condition worsens, call 911

\_\_\_\_\_  
Physician's Signature Date Phone Number

\_\_\_\_\_  
Physician's Name (Printed) FAX Number

## Parent/Guardian:

I request and give permission for my child \_\_\_\_\_ to receive this medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. The school requires parent/guardian to bring medication in its original container. All medication must be labeled with the student's name.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Phone Number Emergency Phone Number

## To be completed by student:

I agree to: Never share my medication with another person. Take medication only as prescribed by my doctor. Carry the medication in its original properly labeled prescriptive or over-the-counter container. I am knowledgeable regarding the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and the privilege(s) of self-administration/self-possession denied.

\_\_\_\_\_  
Student's Signature Date