

### **Daily Asthma Management Plan**

(Identify the things which start an asthma episode. Check each that applies to the student.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust/dust       | <input type="checkbox"/> Change in temperature |
| <input type="checkbox"/> Carpets in the room    | <input type="checkbox"/> Animals               | <input type="checkbox"/> Pollens               |
| <input type="checkbox"/> Food _____             |  | <input type="checkbox"/> Molds                 |

Comments \_\_\_\_\_

### **Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) \_\_\_\_\_

### **Peak Flow Monitoring**

Personal Best Peak Flow Number: \_\_\_\_\_

Monitoring Times: \_\_\_\_\_

### **Daily Medication Plan**

Name	Amount	When to Use
1. _____		
2. _____		
3. _____		
4. _____		

### **Comments/Special Instructions**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **For Inhaled Medications**

- I have instructed \_\_\_\_\_ in the proper way to use his/her medications.  
It is my professional opinion that \_\_\_\_\_ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that \_\_\_\_\_ should not carry his/her inhaled medication by him/herself.

\_\_\_\_\_  
Physician Signature Date

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