ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan ASTHMA

SCHOOL YEAR: 2025-2026

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Identify the things that start an asthma episode (check all that apply to the student)

- ☐ Exercise
- ☐ Chalk Dust
- ☐ Animals
- ☐ Molds
- ☐ Strong odors of fumes
- ☐ Change in temperature
- ☐ Pollens
- ☐ Other _____
- ☐ Respiratory infections
- ☐ Carpets in the room
- ☐ Food

Daily Medication Plan

Name of Medication	Amount/Dose	When to use
1.		
2.		
3.		

EMERGENCY ACTION is necessary when the student has symptoms such as:

_____

***Steps to take during an asthma episode*: Give emergency medications listed below. Seek Emergency Medical Care if the student has any of the following: No improvement 15-20 minutes after initial treatment with medication, and a relative cannot be reached. Continued difficulty breathing. Trouble walking or talking. Stops playing and cannot start activity again. Lips or fingernails are gray or blue.**

Emergency Asthma Medications

Name	Amount/Dose	When to use
1.		
2.		
3.		

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20

Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physician.

The above named child may carry and self-administer his/her metered dose inhaler**.**

Parent/Guardian Signature: (Required) _____ **Date:** _____

Physician's Signature: (Required) _____ **Date:** _____

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Continued Asthma Plan for (Student NAME) _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	Print Name	Date

Parent/Guardian: _____ Cell: _____
Work: _____
Parent/Guardian: _____ Cell: _____
Work: _____