MOUNT PISGAH
CHRISTIAN SCHOOL

Asthma/Reactive Airway/Respiratory Health Plan

Student Name: _____ **DOB:** _____ **Grade:**_____

ALLERGY TO: _____

Physician Treating Student for Asthma: _____ Phone: _____
Other Physician: _____ Phone: _____

Emergency Plan

In an asthma emergency, my child looks like...

_____

_____

Emergency Asthma Medications

Name	Amount	When to Use

Daily Asthma Management Plan

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

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

Comments

_____

_____

Control of School Environment

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

_____

_____

_____

I hereby request that Mount Pisgah Christian School, through its designated authority, supervise/assist in the administering medication to my child, _____, according to the instructions contained in the physician's statement.

I release the school, and any school employee, from any liability for administering this medication.

_____ _____

Parent/Legal Guardian Signature Signature Date

PHYSICIAN'S STATEMENT

NAME OF MEDICATION _____

DOSAGE _____

Frequency medication is to be given during the day:

_____

Expected duration of administration of medicine:

_____

Possible side effects, if any:

_____

For Inhaled Medications

I have instructed _____ in the proper use of his/her

medications. It is my professional opinion that _____

- ☐ should
- ☐ should not

be allowed to carry and use that medication by him/herself.

_____	_____
Physician Signature	Signature Date
_____	_____
Physician Name (Please Print)	Physician Phone Number

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