Date of Plan: ______________

Asthma Medical Management Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant charter school staff and copies should be kept in a place that is easily accessed by the charter school nurse, and other authorized personnel. This plan must be obtained from the student's parent(s) for any student diagnosed with diabetes regardless of whether a Section 504 Plan or Individual Education Plan is later developed as a result of the asthma diagnosis.

Effective Dates: ____

Student's Name: ____

Date of Birth: ______________________ Date of Asthma Diagnosis: _________________

Grade: ____________________________ Homeroom Teacher: _______________________

Physical Condition:

Contact Information

Mother/Guardian: ____

Address: ____

____

Telephone: Home _________________ Work ________________ Cell________________

Father/Guardian: ____

Address: ____

____

Telephone: Home ________________ Work _________________ Cell ________________

Student's Doctor/Health Care Provider:

Name: ____

Address: ____

Telephone: _______________________ Emergency Number: _________________________

Other Emergency Contacts:

Name: ____

Relationship: ____

Telephone: Home ________________ Work ________________ Cell _________________

Notify parents/guardian or emergency contact in the following situations: _________________

____

Hospital/Emergency Department Phone Number: ____________________________

Specifics of Asthma Action Plan to be developed by the School in conjunction with the parent, **school health office and student's physician.**

Signatures

This Asthma Medical Management Plan has been approved by:

____ _________________________
Student's Physician/Health Care Provider Date

I give permission to the school nurse, and other designated staff members of Seven Generations Charter School to perform and carry out the asthma care tasks as outlined by ____________________________'s Asthma Medical Management Plan. I also consent to the release of the information contained in this Asthma Medical Management Plan to student's physician/healthcare provider, emergency healthcare provider and to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety and for the school nurse, and other school staff members who have custodial care of my child to speak with student's physician/healthcare provider or emergency healthcare provider in order to treat and manage my child's asthma.

Acknowledged and received by:

____ ________________________
Student's Parent/Guardian Date

____ ________________________
Student's Parent/Guardian Date