DELAWARE VALLEY SCHOOL DISTRICT

ASTHMA MANAGEMENT PLAN

Student's name_____ Grade _____ Teacher _____

In case of a medical emergency, please contact:

Contact #1: _____ Phone: _____

Contact #2: _____ Phone: _____

Contact #3: _____ Phone: _____

Doctor's contact information:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

My child's asthma symptoms are usually caused by: (circle all that apply)

Exercise Illness Change in season/temp. Allergies*

Other _____

*My child is allergic to _____

My child's asthma symptoms usually include: (circle all that apply)

Wheezing Tightness in chest Cough Shortness of breath

Other (please list) _____

My child's normal peak flow is _____, I treat her/him when the peak flow is below _____.

Please keep my child's teacher updated on his/her asthma care. I will provide the school nurse with the most updated information on my child's asthma. I will also provide to the school all of the medical supplies my child may need.

_____ _____

Parent/Guardian Signature Date