

BELDING AREA SCHOOLS

**SCHOOL-BASED ASTHMA MANAGEMENT PLAN**

Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

**STUDENT INFORMATION:**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Classroom Teacher \_\_\_\_\_

**EMERGENCY INFORMATION:**

Parent/Guardian Name(s) \_\_\_\_\_

\_\_\_\_\_

First Priority Contact \_\_\_\_\_

\_\_\_\_\_

Second Priority Contact \_\_\_\_\_

\_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

**TO BE COMPLETED BY THE CHILD'S DOCTOR:**

**WHAT TO DO IN AN ACUTE ASTHMA EPISODE:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**CALL 911 if:** Review "Signs of an Asthma Emergency" and list any additional symptoms the child may present:
