MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
SCHOOL HEALTH SERVICES

School Asthma Management Plan (SAMP)

Student Name_____ Name of School _____ Today's Date_____
Date of Birth _____
Parent/ Guardian Name_____
Health Care Provider_____

Dear Parent/Guardian,
Please complete and return this form to the **health room** so that school and health staff can better assist your child manage his/her asthma. **All students who have medications for asthma management at school must have this form completed by a parent or guardian or have an Asthma Action Plan (AAP) completed by the health care provider.** This information will be shared with school staff on your child's educational team.

## When my child has an asthma episode, he/she has the symptoms *circled below:*

| | |
|---|---|
| Shortness of breath | Rapid breathing |
| Blue or gray lips | Anxiety/panic |
| Coughing | Wheezing |
| Blue or gray finger tips | Dizziness |

Other _____

## When my child has an asthma episode, it may be caused by the items (triggers) *circled below:*

| | |
|---|---|
| Smoke | Mold |
| Exercise | Chalk/chalk dust |
| Cockroaches | Stress/emotional upsets |
| Animals/pets | Strong smells/perfume |
| Dust/dust mites | Respiratory illness |
| Grass/flowers | |

Weather changes/ very cold or very hot air

Foods_____

Other_____

## My Child:

is seen regularly by a health care provider to monitor asthma Yes No

needs emergency medication two or more times per week Yes No

wakes up at night coughing two or more times per week Yes No

was seen in Emergency Room due to asthma in the past year Yes No

uses a spacer with medication administered by an inhaler Yes No

uses a peak flow meter to monitor his/her asthma Yes No

has an Asthma Action Plan completed by Health Care Provider Yes No

has a normal peak flow reading of _____

needs emergency medication when the peak flow reading is less than _____

needs medical attention when the peak flow reading is less than _____

(OVER)

**My Child's Name** _____ Date of Birth _____

## My child's medications are:

**Control/maintenance/daily medication(s):**

Name _____ Amount & how often to be given_____
Name _____ Amount & how often to be given_____
Name _____ Amount & how often to be given_____
Name _____ Amount & how often to be given_____

## Management at School:

**Self-Carry/Self-Administer-** the student may self-carry and self-administer his/her own rescue medication when:

1. The parent approves and health care provider has signed approval on the "Self-Carry/Self-Administration" line of MCPS 525-13 or on the health care provider Asthma Action Plan.
2. The school nurse assesses the student's skill level and ensures proper and effective use of the medication in school, which includes storage of medication and when to ask for help.

**When my child has an asthma episode at school, health/school staff will do the following:**

- Administer emergency medication if prescribed.
- Permit student to rest in the health room.
- Permit student to self-carry inhaler and self-administer rescue/ emergency medication when the above requirements #1 and #2 are met.
- Contact Parent/guardian when student experiences symptoms and when medication is used.
- Call the rescue squad (911) as deemed necessary in emergency situations.
- Other _____

Parent/Guardian Signature _____Date_____

Parent/Guardian Phone Numbers: Cell _____ Home _____ Work _____

**Reviewed by _____ , School Community Health Nurse on _____**
**Date**

**Discussed with Parent _____**
**Date**

**Copy of plan sent home _____**
**Date**

**Comments:**