Nurse #:_____ **SCHOOL ASTHMA PLAN AND MEDICATION ORDERS** 3419F-1

Place student picture here

Child's Name:	Date of	Grade/School
Allergies:	BUS #: Walk/Drive ☐	PE/Sports: Day/Time/Period:

BRIEF MEDICAL HISTORY:

INHALER and/or EPI PEN KEPT IN: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ COACH ☐ OTHER:____

All SECTIONS ON THIS PAGE TO BE COMPLETED BY CHILD'S LICENSED HEALTHCARE PROVIDER (LHP):

ASTHMA TREATMENT INSTRUCTIONS:

ASTHMA /ALLERGIES TRIGGERS: ☐ None Known

☐ Animals ☐ Pollens ☐ Respiratory colds ☐ Smoke, chemicals, strong odors ☐ Cold Air ☐ Exercise ☐ Other _____

USUAL ASTHMA SYMPTOMS:

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler ☐ Other_____

GO ZONE (GREEN) INFREQUENT/MINIMAL SYMPTOMS

- Symptoms and/or use of quick relief medication < 2 times a week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, short of breath.
- Full participation in physical education and sports

CAUTION ZONE (YELLOW) SIGNIFICANT SYMPTOMS DO NOT LEAVE CHILD UNATTENDED

- If child is using the quick relief inhaler > 2 times a week or requires frequent observation by school staff → Notify parents/nurse
- *If child is coughing, wheezing, and having difficulty breathing:*
  - ☐ Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. If doesn't recover to Green Zone→ Notify parents/nurse if repeated.
  - ☐ Other: _____
- Until symptoms are in the GO (green) ZONE, restrict strenuous physical activity.
- If no improvement after repeated dose Call 911—See below

STOP ZONE (RED) CALL 911 DO NOT LEAVE CHILD UNATTENDED

If child is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working.

- *Call 911*

☐ Give 4 puffs quick relief inhaler (or nebulizer treatment) and notify parents and school nurse.

☐ This student needs Epi-Pen® for severe asthma attacks and ☐ can carry & self administer Epi-Pen® ☐ needs help giving the Epi-Pen®.

☐ Other: _____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ N/A

☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to recess☐ / physical education☐

☐ May repeat 2 puffs of quick relief inhaler if symptoms recur. Notify Nurse & Parent if occurs.

Daily Controller meds: _____

☐ Takes daily controller medications at home ☐ Takes daily controller medications at school Which meds and time _____

Quick relief medication orders: *(check the appropriate quick relief med)* ☐ Uses inhaler with spacer

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) as needed every 4 hours for cough/wheeze

☐ Levalbuterol 2 puffs (Xopenex®) as needed every 4 hours for cough/wheeze

☐ Other (i.e., ☐ EpiPen® ☐ EpiPen, jr.® / Nebulizer) _____

SIDE EFFECTS of medication(s): _____

☐ This student demonstrated correct use of the inhaler to the LHP. This student is able to carry & use inhalers by himself/herself. ☐ YES ☐ NO

Start date:	End date: (not to exceed current school year) ☐ Last day of school	Other:
LHP Signature:	Print Name:	
Date:	Telephone #:	Fax#:

TO BE COMPLETED BY PARENT OR GUARDIAN:

EMERGENCY CONTACTS

Mother/Guardian	**Father/Guardian**
Name	Name
Home Phone	Home Phone
Work Phone	Work Phone
Other	Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My child may carry and use his/her asthma inhaler: ☐ YES ☐ NO Provide extra for office? ☐ YES ☐ NO

My child may carry and is trained to self-administer his/her own Epi-Pen®: ☐ YES ☐ NO Provide extra for office? ☐ YES ☐ NO

Parent:

- I understand that the school board or the school district's employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively self-administering the medication.
- A new LHP Order/Emergency Care Plan (ECP) for Asthma and Parent/Student Agreement for an Inhaler/EpiPen must be submitted each school year.
- I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the school nurse.

I have reviewed the information on this School Asthma Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions. I authorize the exchange of medical information about my child's asthma between the LHP office and school nurse.

Parent/Guardian Signature Date

Student:

- I have demonstrated the correct use of the inhaler to the medical provider and/or school nurse.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering, I will report to an adult at school if the nurse is not available or present.

Student's Signature Required Date

All school aged children who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their health care professional and kept on file in the school office (RCW 28A.210.370). The form must also be signed by a parent/guardian. The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose). The provider's office is encouraged to fax the plan to the student's school nurse.

The school plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management.

CARRYING AND ADMINISTERING AND QUICK RELIEF INHALERS:

- Most students are capable of carrying and using their quick relief inhaler by themselves. The student, student's parents, school nurse and healthcare provider should make this decision. The school nurse should also evaluate technique for effective use.

For District Nurse's Use Only:

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self administer the medication.

Expiration date of medication: _____ Device(s) if any, used _____ Date: _____ Nurse signature: _____