SCHOOL ASTHMA PLAN & MEDICATION ORDERS

Place student picture here

Nurse's name/phone:

NAME: **Birthdate:**

Grade: **School:** ☐ **Bus #** ☐ **Walk** ☐ **Drive**

☐ **History of anaphylaxis** **PE/Sports:** Day/Time/Periods

Brief medical history:

Date of last hospitalization:

Inhaler(s) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

Epinephrine auto-injector (**EAI**) location: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER:

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

ASTHMA TREATMENT INSTRUCTIONS: (check all that apply)

Asthma Triggers: ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens ☐ Exercise

☐ Smoke, chemicals, strong odors ☐ Other _____ (i.e., foods, emotions, insects, etc.)

USUAL ASTHMA SYMPTOMS: (check all that apply)

☐ 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 per week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, and short of breath
- Full participation in physical education and sports

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

- If Student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff ➔**Notify parents and nurse**
- If Student is coughing, wheezing, and having difficulty breathing:
  - ☐ Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. ➔**Notify parents and nurse if repeated**
  - ☐ Other: _____
- Until symptoms are in the GO ZONE (green), restrict strenuous physical activity.
- **If no improvement after repeated dose Call 911—See below**

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

If Student 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 EAI for severe asthma attacks and ☐ Can carry and self-administer EAI.

☐ Needs help giving the EAI. ☐ Other: _____

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

☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to ☐ PE ☐ As needed with no less than 2 hours between doses unless student complains of symptoms.

☐ May repeat 2 puffs of quick relief inhaler if symptoms occur. ➔**Notify parents and nurse if occurs.**

Quick relief medication orders: (check the appropriate quick relief med(s) ☐ 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 _____ Epinephrine auto-injector ☐ 0.3 mg ☐ Jr. 0.15 mg

☐ **Daily Controller meds:** _____ dose _____ time _____

☐ Takes daily controller medications at home ☐ Takes daily controller medications at school

SIDE EFFECTS of medication(s): increased heart rate, shakiness.

This student demonstrated correct use of the inhaler in the LHP's office as required. ☐ **Yes** ☐ **No**

This student's asthma is life-threatening ☐ **Yes** ☐ **No**

This student is able to carry and use inhalers ☐ **Yes** ☐ **No**

LHP Signature:		LHP Print Name:	
Start date		End date ☐ Last day of school ☐ Other:	
Date:		Telephone #:	Fax #:

Student:

TO BE COMPLETED BY PARENT OR GUARDIAN

EMERGENCY CONTACTS					
Mother/Guardian	Name		Father/Guardian	Name	
	Home Phone			Home Phone	
	Work Phone			Work Phone	
	Other			Other	

ADDITIONAL EMERGENCY CONTACTS					
1.		Relationship:		Phone:	
2.		Relationship:		Phone:	

My student's asthma is life-threatening? ☐ Yes ☐ No

My student may carry and use his/her asthma inhaler? ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No

My student may carry and is trained to self-administer his/her own EAI? ☐ 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.
- The permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that the student is not safely and effectively self-administering the medication.
- A new LHP order/school asthma and Parent/Student Agreement for an Inhaler/EAI must be submitted each school year.
- I understand that if any changes are needed on the school asthma plan, it is the parent's responsibility to contact the school nurse.
- I have reviewed the information on this School Asthma Plan 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 Signature (Required) **Date**

All school aged students who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their LHP and kept on file in the school office (RCW 28A.210.320 370). 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 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 health care provider should make this decision. The school nurse should also evaluate technique for effective use.

School Nurse Reviewed **Date**

For School Registered 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

Device(s) if any, used Expiration date(s):

Registered Nurse Signature **Date**