DOES YOUR CHILD HAVE EVERYTHING WE NEED TO MAKE THIS A SAFE, HEALTHY SCHOOL YEAR?

It's a new year!
That means we need to work together to keep our students with asthma safe at school...

• Be sure to give the school updated asthma information.
• Talk to us about medications.
• Bring an Asthma Action Plan to school.

Questions? Call (school nurse) ________________
at (phone) ________________

THANKYOU!
Authorization for Administration of Inhaled Asthma Medication
(Use a separate authorization form for each medication)

School: ____________________________________________
Student's Name: (First/Mi/Last) __________________________
Sex: (please circle) Female  Male  Birthday: _____/____/____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:
Physician's Name: ______________________________________
Telephone Number: __________________________ Fax Number: __________________________
Emergency Contact Number: __________________________
Diagnosis: __________________________________________
Name of Medicine: ______________________________________
Form: __________________________ Dose: __________________________

Is the child knowledgeable about his/her asthma medication?  □ Yes  □ No
Has the child demonstrated the proper technique in administering medication?  □ Yes  □ No
Medicine is administered daily. Time: __________________________
Medicine is administered when needed. Indications: __________________________________________

If needed, how soon can administration of medicine be repeated? __________________________
The medication cannot be repeated more than __________________________
Side effects: __________________________
Comments: __________________________________________

( ) I have instructed __________________________ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

( ) It is my professional opinion that __________________________ should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: __________________________

FOR COMPLETION BY PATIENT
Mother's Name: ______________________________________
Father's Name: ______________________________________
Mother's Work Telephone: __________________________ Father's Work Telephone: __________________________
Home Telephone: __________________________ Emergency Number: __________________________

Is the child authorized to carry and self-administer inhaled asthma medication?  □ Yes  □ No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature & Date: __________________________
# Asthma Action Plan

## General Information:
- Name ____________________________
- Emergency contact ____________________________
- Physician/Health Care Provider ____________________________
- Physician Signature ____________________________
- Phone numbers ____________________________
- Phone numbers ____________________________
- Date ____________________________

<table>
<thead>
<tr>
<th>Severity Classification</th>
<th></th>
<th>Triggers</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Mild Intermittent</td>
<td>O Moderate Persistent</td>
<td>O Colds</td>
<td>1. Pre-medication (how much and when)</td>
</tr>
<tr>
<td>O Mild Persistent</td>
<td>O Severe Persistent</td>
<td>O Smoke</td>
<td>2. Exercise modifications</td>
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<td>O Weather</td>
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<td>O Exercise</td>
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<td>O Air pollution</td>
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<td>O Food</td>
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<td>O Other</td>
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</tbody>
</table>

## Green Zone: Doing Well

**Symptoms**
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

**Peak Flow Meter**
More than 80% of personal best or ______

## Yellow Zone: Getting Worse

**Symptoms**
- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

**Peak Flow Meter**
Between 50 to 80% of personal best or ______ to ______

Contact Physician if using quick relief more than 2 times per week.

## Red Zone: Medical Alert

**Symptoms**
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

**Peak Flow Meter**
Between 0 to 50% of personal best or ______ to ______

---

**Ambulance/Emergency Phone Number:**

Continue control medicines and add:

Medicine ____________________________
How Much to Take ____________________________
When To Take It ____________________________

Go to the hospital or call for an ambulance if
- Still in the red zone after 15 minutes
- If you have not been able to reach your physician/health care provider for help
- Lips or fingernails are blue

Call an ambulance immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Other
Charter School of Excellence
Authorization for Medication to be taken during School Hours

I request that my child, __________________________, Date of Birth __________, Grade __________, be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the medication policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dose.

I agree to waive the School District, their officers, representatives and employees of liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risk of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claims for acts of negligence by employees of the School District.

Furthermore, as a parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Charter School of Excellence, officers, and their employees against loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray the damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursement or indemnification.

Name of medication to be given at school: ______________________________________

Other medications student is taking: ____________________________________________

Allergies: __________________________

Parent/Guardian Signature ________________ Date ________________ Emergency Contact ________________

The Physician Completes the Following Section:

Name of medication to be given at school: ______________________________________

Diagnosis for which the medication is given: ______________________________________

Dosage: __________________________ Time(s): __________________________ Route: ________________

Significant side effects: _________________________________________________________

Dates Medication to be given from: __________________________ to __________________________

Can this medication be adjusted to accommodate class schedule: yes or no
If yes, by how much time? _________________________________________________________

Other information: ____________________________________________________________

Printed Physician Name __________________________ Physician Phone Number and Fax Number __________________________

Physician Signature ____________________________________

5/2010
Asthma Individual Health Plan*  

*Parents to establish plans with School Nurse and Health Care Provider

Date: _____________

Student: ____________________________  Grade: _______________________

Birthdate: ___________________________  School: _______________________

Parent/Guardian: ____________________  Phone (home): __________________

Address: ____________________________  Phone (work): __________________

Parent/Guardian: ____________________  Phone (home): __________________

Address: ____________________________  Phone (work): __________________

Emergency Contact: __________________ Relationship: _________________ Phone: __________________

Emergency Contact: __________________ Relationship: _________________ Phone: __________________

Student’s Health Care Provider: ____________________________  Phone: __________________

Insurance Company: ____________________________  Policy Number: ____________________________

For information on health care insurance, call Healthy Mothers Healthy Babies toll free number: 1-800-322-2588

Preferred Hospital: ____________________________

Asthma Triggers: (Check each that applies to the student.)

☐ Exercise  ☐ Food  ☐ Pollens  ☐ Stress
☐ Respiratory Infections  ☐ Strong Odors or Fumes  ☐ Molds  ☐ Cigarette Smoke
☐ Change in Temperature  ☐ Chalk Dust  ☐ Other ____________________________
☐ Animals  ☐ Carpets in the Room  ☐ Other ____________________________

Comments: ____________________________

Control of School Environment: (List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma attack.)

__________________________________________________________________________

Peak Flow Monitoring: Personal Best Peak Flow Number ____________________________

Monitoring Times: ____________________________

Green zone: ____________________________  Yellow zone: ____________________________  Red zone: ____________________________

Daily Medication Plan

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Amount</th>
<th>When to Use</th>
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<tbody>
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<td>1.</td>
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<td>3.</td>
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</table>

Level of Independence (attach copy of Authorizations for Administration of Oral Medications)

Student is capable of self-administering medications: __yes  __no
Student can reliably report asthma symptoms: __yes  __no

Level of Nursing Care  □ A  □ B  □ C  □ D
SCHOOL EMERGENCY ASTHMA PLAN
Guidance for Non-licensed School Personnel
Asthma Individual Health Plan

Student: ___________________________ DOB: ___________________________

Parent: ___________________________ Phone:(H) ___________________________

Second Contact Person: ___________________________ Phone: ___________________________

Common Asthma Attack Signs and Symptoms:
Persistent coughing       Wheezing while breathing in or out       Shortness of breath       Tightness in chest

Steps to take during an asthma attack:
1. Give medications as listed below.
2. Have student return to classroom if: ___________________________
3. Contact parent if: ___________________________

Emergency Asthma Medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>How much</th>
<th>When To Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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</table>

Student can self-administer medications?  □ Yes  □ No

CALL 911 NOW FOR:
- Rapid, labored breathing
- "Pulling in" of neck and chest with breathing
- Unable to talk in full sentences
- Becoming anxious
- Nasal flaring
- Sweaty, clammy skin

AND GIVE EMERGENCY MEDICATIONS LISTED ABOVE

NEVER SEND A CHILD WITH A SUSPECTED ASTHMA ATTACK ANYWHERE ALONE

Other significant health condition(s): ___________________________

Preferred Hospital: ___________________________

Special Instructions:
□ If child is having difficulty breathing, do not allow the child to walk home unaccompanied from school.
□ Call parent if student develops asthma symptoms.
□ Medications for field trip  □ Yes  □ No

Distribution List
□ Teaching staff
□ PE teacher
□ Secretary
□ Bus driver
□ Playground supervisor
□ Principal
□ ___________________________

Parent’s Signature ___________________________ Date ___________________________

Nurse’s Signature ___________________________ Date ___________________________
Asthma Individual Health Plan

<table>
<thead>
<tr>
<th>Equipment and supplies provided by parent</th>
<th>Disaster Supplies</th>
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<tr>
<td><em>Nebulizer for delivery of medications</em></td>
<td><em>Medications for 3 days</em></td>
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<tr>
<td><em>Peak Flow Meter for monitoring</em></td>
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<tr>
<td><em>Spacer or holding chamber</em></td>
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<tr>
<td><em>Other</em></td>
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</table>

STUDENT HEALTH EDUCATION (Complete as applicable)

<table>
<thead>
<tr>
<th>Topics</th>
<th>Taught (date)</th>
<th>Demonstrated Mastery (date)</th>
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<td>• Purpose</td>
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<td>• Frequency</td>
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<td>• Effectiveness</td>
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<tr>
<td>• Side Effects</td>
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<tr>
<td>Other (i.e., adaptation to illness; smoking cessation class referral)</td>
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<td>With Student</td>
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<tr>
<td>Review of Emergency Care Plan</td>
<td>With Parent</td>
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</table>

STUDENT OUTCOMES

1. Student will participate in school activities with modifications as needed.
   Modifications: ________________________________

2. Student will demonstrate/describe checked items under “Health Education.”

3. Other:  ______________________________________

Plan reviewed with parent: ____________________________

(Parent’s signature)   (date)   (School nurse’s signature)   (date)

Reviewed and/or updated:

(Parent’s signature)   (date)   (School nurse’s signature)   (date)

New staff trained: ____________________________

Date: ____________________________

New staff trained: ____________________________

Date: ____________________________

AMES: Asthma Management in Educational Settings  American Lung Association of Washington-02/01  3