AMERICAN LUNG ASSOCIATION®

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) _____

THANK YOU!

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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 Birthdate: ____/____/____

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:_____ ❑Yes ❑ No

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

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General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification

○ Mild Intermittent ○ Moderate Persistent
○ Mild Persistent ○ Severe Persistent

Triggers

○ Colds ○ Smoke ○ Weather
○ Exercise ○ Dust ○ Air pollution
○ Animals ○ Food
○ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

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 _____

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

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

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 _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

○ Take quick-relief medication every 4 hours for 1 to 2 days
○ Change your long-term control medicines by _____
○ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

○ Take quick-relief treatment again
○ Change your long-term control medicines by _____
○ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

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 _____

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
○ _____

Call an ambulance immediately if the following danger signs are present

○ Trouble walking/talking due to shortness of breath
○ Lips or fingernails are blue

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

5/2010

_____

Physician Signature

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Asthma Individual Health Plan*

Section 504 Plan ☐

Date:_____

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

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

	Medication Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

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

Student is capable is 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 Section 504 Plan ☐

Guidance for Non-licensed School Personnel

Asthma Individual Health Plan

Student:_____DOB:_____

Parent:_____Phone:(H)_____(W)_____

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:

	Medication Name	How much	When To Use
1.	_____	_____	_____
2.	_____	_____	_____

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 Section 504 Plan □

Equipment and supplies provided by parent	__ Nebulizer for delivery of medications __ Peak Flow Meter for monitoring __ Spacer or holding chamber __ Other _____	Disaster Supplies __ Medications for 3 days

STUDENT HEALTH EDUCATION (Complete as applicable)

Topics	Taught (date)	Demonstrated Mastery (date)
Triggers		
Prevention Strategies Acute Signs/Symptoms		
Medications		
• Purpose		
• Method of Administration		
• Dosage		
• Frequency		
• Effectiveness		
• Side Effects		
Other (i.e., adaptation to illness; smoking cessation class referral)		
	With Parent	With Student
Review of Emergency Care Plan		

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: Copy sent home:

_____ _____ _____ _____
(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:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____