SUSSEX COUNTY PUBLIC SCHOOLS

Asthma Health Care Action Plan and Medication Administration Authorization

TO BE COMPLETED BY PARENT:

Child's Name _____Date of Birth _____ School _____ Grade _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ Zip _____

Emergency Contact _____Relationship _____ Phone _____

Name of Physician/Nurse Practitioner/Physician Assistant _____ Office Phone (___) _____
Office Fax (___) _____

What triggers your child's asthma attack? (Check all that apply)

☐ Illness ☐ Cigarette or other smoke Food_____
☐ Emotions ☐ Exercise/physical activity Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen
☐ Weather changes ☐ Chemical odors Other: _____

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

☐ Cough ☐ Tightness in chest ☐ Rubbing chin/neck
☐ Shortness of breath ☐ Breathing hard/fast ☐ Feeling tired/weak
☐ Wheezing ☐ Runny nose ☐ Other _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The child's asthma is: ☐**Intermittent** ☐**Mild Persistent** ☐**Moderate Persistent** ☐**Severe Persistent** ☐ **Exercise-induced**

SYMPTOMS &/OR	**Peak Flow Monitoring**	**Treatment**		
WELL • Usual medications control asthma • No cough or wheeze • Able to sleep through the night • No rescue meds needed • No activity restrictions (PE & recess are okay)	**GREEN ZONE** **Personal Best =** _____ _____ to _____	**Medication**	**How Much**	**When**
		Relievers/Rescue		
		☐Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	☐ **2 puffs or 1 nebulizer treatment 5-15 min. before physical activity**
		☐ **Other** _____		
		Controllers		
		☐ Inhaled Corticosteroid_____		
		☐ Advair		
		☐ Symbicort		
		☐ Other _____		
		Leukotriene Modifier: ☐ Singulair		
		☐Other _____		
		Other _____		
SICK • Needs reliever medications more often • Increased asthma symptoms (shortness of breath, cough, chest pain • Wakes at night due to asthma • Unable to do usual activities	**YELLOW ZONE** _____ to _____	1. ☐ Continue daily controller medications 2. ☐ Give albuterol 2-6 puffs (1 min between puffs) with spacer or 1 nebulizer treatment, wait 20 min 3. ☐ If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 mins. **Call parent and/or MD** **<u>If no improvement , CALL 911</u>** **If child returns to Green Zone:** ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ No physical activity ☐ Physical activity as tolerated i.e. PE & recess at school		
EMERGENCY • Reliever medications do not help • Very short of breath • Constant cough	**RED ZONE** <_____	☐ **Give albuterol 2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.** **<u>If there is no improvement, call parent and/or 911.</u>** **<u>Call 911 immediately if:</u>** • Child is struggling to breathe and there is no improvement in 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing		

PATIENT/STUDENT INSTRUCTIONS:

☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student <u>can carry and use his/her inhaler at school</u>
☐ Student is to notify his/her designated school health officials after using inhaler per school protocol
☐ Student needs supervision or assistance to use his/her inhaler ☐ Student should **<u>NOT</u>** carry his/her inhaler while at school

_____ _____ _____ ☐ **Valid for current school year**
HEALTH CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER'S NAME** **DATE**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

_____ _____
PARENT SIGNATURE **DATE**

CINCH
Virginia Asthma Coalition

Cc: principal ____ office staff ____ librarian ____cafeteria mgr. ____ bus driver/transportation ____ Coach/PE ____ teachers ___ rev: January, 2008

Student's Name:_____ DOB:_____ School: _____
Medication Allergies:_____ School Year: _____

I, _____, parent or legal guardian of above student, request that the principal's designee at _____ School administer the prescribed medication and provide care to my child as indicated on the *Asthma Health Care Action Plan* dated _____. I give the principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement.

I also understand that I am to abide by the school division regulations as stated below:

- It is my child's responsibility to come to the clinic to take his/her medication.
- Parent or guardian must bring medication into school office or clinic. Medication cannot be transported on buses or by students.
- The first dose of a new medication should be given at home.
- Prescription medication must have a current prescription label that corresponds with the written authorization.
- Any changes in a medication require a new written authorization and corresponding change in the prescription label.
- Parent or guardian must provide medications/equipment required to administer medications or provide special medical care.
- Left over medication must be picked up at the end of the school year or it will be discarded.

- Students with a diagnosis of asthma may possess and self-administer inhaled asthma medications during the school day, at school-sponsored activities, and while on the bus or other school property provided the following conditions are met:
  - ✓ The student must have written consent from a parent or guardian **and** from a physician or nurse practitioner that identifies the name, dosage and frequency of medication and circumstances which warrant such medication to be self-administered.
  - ✓ The physician must confirm that the student demonstrates ability to safely and effectively self administer medication;
  - ✓ The parent must provide an individualized health care plan including emergency procedures for any life-threatening conditions.
  - ✓ The permission to possess and self-administer inhaled asthma medications shall be effective for one year, defined as 365 calendar days, and must be renewed annually.
  - ✓ The parent or guardian will be notified by a school official before any limitations or restrictions are imposed upon a student's possession and self-administration of inhaled asthma medications.
  - ✓ It is the student's responsibility to notify a teacher or school health official after self administering medication.

I give permission to share information about my child's asthma with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation and cafeteria manager as appropriate. I give the principal or his designee the authority to call the rescue squad or take my child to a hospital emergency room in case of emergency.

Parent/Guardian Signature _____ Date _____

Parent/Guardian PRINTED Name _____

PHONE: Home:_____ Work:_____ Cell:_____

Student's Name:_____

School Use:

Health care plan information provided by _____ to the following staff:

Names of Persons and Date	*Names of Persons and Date*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Staff members trained to administer medication and assist with this student's care at school in the absence of the nurse:

Name of Person	*Location or Room Number*	*Date Trained*
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		