ASTHMA CARE PLAN AND MEDICATION ORDERS

Plan ____ of ____

Place student picture here

STUDENT NAME | **Birthdate**

Grade | **School** | ☐ **Bus #** ☐ **Walk** ☐ **Drive** | **Weight:** **Height:**

☐ **History of anaphylaxis** | **Brief medical history:**

Asthma Triggers (check all that apply) ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens
☐ Respiratory illness/virus ☐ 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 ____

Inhaler(s) location: ☐ Office ☐ Backpack ☐ On person ☐ Other______________________

Epinephrine auto-injector(s) (**EAI**) location ☐ Office ☐ Backpack ☐ On person ☐ Other______________________

This Section to be Completed by a Licensed Healthcare Provider (LHP)

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 shortness of breath. Full participation in physical education and sports is allowed.

If student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff
➔ **Notify school nurse-phone # __________________________ and parent/guardian.**

GREEN ZONE Peak Flow Range _____ to _____
☐ N/A Peak Flow

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

SYMPTOMS INCREASE: Cough, wheeze, chest tightness, or shortness of breath, can do some, but not all, usual activities

ADMINISTER ☐ **Quick-relief Medication:** ________________________ **Number of puffs:** __________
☐ **Use spacer/chamber with inhaler**
OR ☐ **Quick-relief Medication via Nebulizer**: ____________________ **Dosage:** __________

Can repeat every _____ minutes up to maximum of _____ doses

- If symptoms (and peak flow, if used) resolve student returns to GREEN ZONE guidance
- If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
  Administer ☐ **Quick-relief Medication:** ________________________ **Number of puffs:** ______
  OR ☐ **Nebulizer** (2nd dose)

Contact school nurse (if available) and parent/guardian. Student should not remain at school at this point. Continue to stay with and monitor the student until parent/guardian arrives.

YELLOW ZONE Peak Flow Range _____ to _____

EMERGENCY ZONE (RED) *EXTREME SYMPTOMS 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)
☐ Administer epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)
☐ Other ____
Contact school nurse (if available) and parent/guardian. Adult stays with student

RED ZONE Peak Flow Range Below: ________

EXERCISE PRE-TREATMENT: ☐ N/A PE/Sports: Day/Time/Periods ____________________________________

☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to PE or other strenuous exercise

If asthma symptoms occur during exercise, follow CAUTION ZONE (YELLOW) instructions. Notify nurse and parent/guardian if occurs.

Daily Controller Medication_______________________________________ Dose________________Time__________

☐ Takes daily controller medication at home ☐ Administer daily controller medication at school

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

This student demonstrated correct use of the rescue inhaler and EAI in the LHP's office as required ☐ Yes ☐ No

☐ Student can carry and self-administer rescue inhaler and EAI ☐ Needs help administering rescue inhaler and EAI

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

Parent/Guardian			Parent/Guardian		
	Name			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 EpiPen® auto-injector? ☐ 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 the student is not safely and effectively self-administering the medication.
- A new LHP order/school 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 school asthma plan, 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 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.

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

Device(s), if any, used:	Expiration date(s):
School Nurse Signature	**Date**