

Place student picture here

Child's Name: _____	Date of Birth: _____	Grade: _____
Allergies _____	BUS #: _____	Walk/Drive <input type="checkbox"/>

MEDICAL HISTORY: _____
 INHALER and/or EPI PEN KEPT IN: OFFICE BACKPACK ON PERSON COACH OTHER: _____

All SECTIONS ON THIS PAGE TO BE COMPLETED BY CHILD'S LICENSED HEALTHCARE PROVIDER (LHP):
ASTHMA TREATMENT INSTRUCTIONS:

ASTHMA /ALLERGIES TRIGGERS None Known
 Animals Pollens Respiratory colds Smoke, chemicals, strong odors Cold Air Exercise Other _____

USUAL ASTHMA SYMPTOMS:
X Cough X Wheeze X 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 a week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, short of breath.
- Full participation in physical education and sports

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

- If child is using the quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify parents/nurse**
- ***If child is coughing, wheezing, and having difficulty breathing:***
 Give 2 puffs of quick relief inhaler. May repeat in 10 minutes if doesn't recover to Green Zone → **Notify parents/nurse if repeated.**
 Other: _____
- Until symptoms are in the GO (green) ZONE, restrict strenuous physical activity.
- If no improvement after repeated dose **Call 911—See below**

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

If child is very short of breath, can see ribs during breathing, difficulty walking and 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 Epi-Pen® for severe asthma attacks and can carry & self administer Epi-Pen® X needs help giving the Epi-Pen®.
- Other: _____

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

- Give 2 puffs of quick relief inhaler 15- 30 minutes prior to recess / physical education
- May repeat 2 puffs of quick relief inhaler if symptoms recur. **Notify Nurse & Parent if occurs.**

Daily Controller meds: _____
 Takes daily controller medications at home Takes daily controller medications at school Which meds and time _____

Quick relief medication orders: (check the appropriate quick relief med) 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 (i.e., EpiPen®/ Nebulizer) _____

SIDE EFFECTS of medication(s): _____
 This student demonstrated correct use of the inhaler to the LHP. This student is able to carry & use inhalers by himself/herself. YES NO

Start date: _____ **End date:** _____ (not to exceed current school year) **Last day of school:** _____

LHP Signature: _____	Print Name: _____	Date: _____
Telephone #: _____	Fax #: _____	

TO BE COMPLETED BY PARENT OR GUARDIAN:

EMERGENCY CONTACTS

Mother/Guardian

Father/Guardian

Name	Name
Home Phone	Home Phone
Work Phone	Work Phone
Other	Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My child may carry and use his/her asthma inhaler: YES NO Provide extra for office? YES NO

My child may carry and is trained to self-administer his/her own Epi-Pen®: 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 your child is not safely and effectively self-administering the medication.
- A new LHP Order/Emergency Care Plan (ECP) for 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 ECP, 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's Signature Required _____

Date _____

All school aged children who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their health care professional and kept on file in the school office (RCW 28A.210.370). 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 provider's office is encouraged to fax the plan to the student's school nurse.

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 healthcare 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.

Expiration date of medication: _____ Device(s) if any, used _____ Date: _____

Nurse signature: _____