EMERGENCY ASTHMA PLAN / MEDICATION ORDER

Student's Full Legal Name:_____DOB:_____Grade: _____
(please print)

Parent/Legal Guardian's Name: _____

Phone: (H)_____(W)_____(C)_____

Second Contact Person:_____Phone: _____

NEVER SEND A CHILD WITH A SUSPECTED ASTHMA SYMPTOM(S) ANYWHERE ALONE!

SIGNS AND SYMPTOMS:

- Persistent coughing
- Shortness of Breath
- Unable to talk in full sentences
- "Pulling in" of neck & chest with breathing
- *Tightness in Chest
- *Nasal flaring
- *Wheezing
- *Sweaty, clammy skin
- *Rapid, labored breathing
- *Becoming anxious

STEPS TO TAKE DURING AN ASTHMA ATTACK:

1. Give medications as listed below.
2. Have student return to classroom **if:** _____
3. Contact parent **if:** _____
4. CALL 911
   - If no improvement in 15-20 minutes after initial treatment with medication and a parent/legal guardian cannot be reached.
   - Medications are not available.
   - Lips or nail beds turning gray or blue **OR** paling of lips or nail beds (dark complexions).
   - Decreasing or loss of consciousness.

OTHER SIGNIFICANT HEALTH CONDITIONS: _____

TO BE COMPLETED AND SIGNED BY LICENSED HEALTH PROFESSIONAL

ASTHMA SEVERITY: Mild☐ Moderate☐ Severe☐

Medication: _____Dosage:_____Route:_____Time:_____

If "prn" specify length of time between doses:_____

Please list the side effects of the medication(s):_____

Emergency procedure in case of side effects:_____

Duration of Order: From:_____ To:_____ Current School Year: ☐Yes ☐No

Child was instructed and demonstrated use? ☐Yes ☐No May Self-carry/Self-administer: ☐Yes ☐No

Licensed Health Care Professional's Signature: _____ Date: _____

Licensed Health Care Professional's Printed Name: _____

Phone #:_____ Fax #:_____

Physical Address:_____
Street City Zip

TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

Student's Full Legal Name:_____DOB:_____Grade: _____

Student: Rides Bus #____ Walks ☐ Picked up ☐ Drives ☐

Asthma History:
How long has your child had asthma?_____ Has your child been hospitalized for asthma? ☐ Yes ☐ No

Dates of Hospitalizations: _____

Triggers: ☐ None Known

☐ Pollen ☐ Mold ☐ Respiratory Infection/illness ☐ Weather
☐ Exercise ☐ Chemicals/irritants/strong odors ☐ Smoke
☐ Other: _____

DAILY CONTROLLER MEDICATION (Given At Home):

Medication: _____ _____ _____
Amount: _____ _____ _____
Frequency: _____ _____ _____

History of Life threatening allergy/severe allergic reaction: ☐ Yes ☐ No Allergic to? _____

During the last school year, approximately how many days of school did your child miss due to Asthma? _____
Does your child recognize the asthma symptoms? ☐ Yes ☐ No
If no, how does your child describe the symptoms? _____

I certify that I am the parent/legal guardian or other person in legal control of the above identified child. My signature indicates my involvement and agreement with the information and plan as stated above. I request that this medication be given as ordered by the licensed health care provider. I give permission for Health Services Staff to communicate about this condition with Licensed Health Care Provider's office, 911 responders and school staff working with my child. All medication supplied must be unexpired and in its original container provided with instructions as noted above by the licensed health care provider. Any permission to possess and self-administer medication may be revoked by the principal or school nurse if it is deemed that your child is not safely and effectively able to carry or self-administer.

I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No
I will supply backup inhaler for health room. ☐ Yes ☐ No

Parent/Legal Guardian's Signature:_____ Date: _____

FOR LICENSED NURSE USE ONLY

This child has demonstrated to the licensed nurse, the skill to use the medication and any device necessary to administer the medication ordered whether self-administered or not. ☐ Yes ☐ No

This plan has been reviewed/approved by a registered nurse.

Licensed Practical Nurse's Signature (if applicable):_____ Date: _____

Registered Nurse's Signature:_____ Date: _____

A signed copy of this plan will be kept in the Health Room. Recommendation sent to school administration to self-carry per District Policy 3419.

Epi-pen:
In Health Room? ☐ Yes ☐ No Expiration Date: _____
Carries In: ☐ Backpack ☐ Purse ☐ Other:_____

Inhaler:
In Health Room? ☐ Yes ☐ No Expiration Date: _____
Carries In: ☐ Backpack ☐ Purse ☐ Other:_____