Haysville Public Schools Asthma Care Plan and Medication Order for School

PARENT/GUARDIAN to complete this portion and sign completed form.	
Student Name:	Birthdate:
Parent/Guardian Name:	Phone:
Healthcare Provider Name:	Phone:
Triggers: ☐ Weather (cold, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other:	
☐ Life Threatening Allergy – Specify:	

The medication listed below must be taken during school hours as directed by the health care provider. I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. / I hereby request that Haysville Schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I also certify that my child has received least one dose of the medication requested above and has not had any adverse reactions to it. / I further release Haysville Schools and school personnel from liability when my child self-carries and self-administers medication. / I approve of this Asthma Care Plan.

_____	_____	_____	_____
Parent/Guardian Signature	Date	School Nurse Signature	Date

HEALTH CARE PROVIDER to complete all items, **SIGN**, and **DATE** completed form	QUICK RELIEF (RESCUE) MEDICATION: ☐Albuterol ☐Xopenex ☐Other: _____ Common side effects: ↑heart rate, tremor ☐ Have student use spacer with inhaler. Controller medication used at home: _____ ☐ If temperature is below _____ degrees F, student should stay inside.
IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Present - No current symptoms - Doing usual activity	Pretreat strenuous activity: ☐N/A ☐ Scheduled ☐ Student/Parent request Give QUICK RELIEF MED _____minutes before activity Number of puffs: _____ ☐ Repeat in _____ hours, if needed, for additional physical activity.
YELLOW ZONE: Mild Symptoms - Trouble breathing - Wheezing - Frequent cough - Complains of tight chest - Not able to do activities, talking in complete sentences - Peak flow:_____ - _____	1. Stop physical activity 2. Give QUICK RELIEF MED: Number of puffs: _____ Frequency: _____PRN 3. Stay with student and maintain sitting position 4. **REPEAT** QUICK RELIEF MED, if not improving in 10-15 minutes with ☐ 2 puffs / ☐ 4 puffs / _____ puffs 5. Student may return to normal activities, once symptoms are relieved 6. **If symptoms do not improve in 15 minutes or worsen following quick relief medication, follow RED ZONE plan.**
RED ZONE: Severe Symptoms - Coughs constantly - Struggles to breathe - Trouble talking (only speaks 3-5 words) - Skin of chest and/or neck pull in with breathing - Lips/fingernails gray or blue - ↓ Level of consciousness - Peak flow < _____	1. Give QUICK RELIEF MED: # of puffs: _____ - Refer to anaphylaxis plan if student has life-threatening allergy 2. Call 911 3. Stay with student and remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs or ☐ 4 puffs every 5 minutes until EMS arrives.

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and, in my opinion, <u>can carry and use his/her inhaler at school independently with approval from school nurse.</u>

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

_____	_____	_____	_____
Health Care Provider Signature	Print Provider Name	Date	Phone # / Fax #