

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: <input type="checkbox"/> Weather (cold, wind) <input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Other:	
<input type="checkbox"/> 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 at 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

<p>HEALTH CARE PROVIDER to complete all items, SIGN, and DATE completed form</p>	<p>QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex <input type="checkbox"/> Other: _____</p> <p>Common side effects: ↑heart rate, tremor <input type="checkbox"/> Have student use spacer with inhaler. Controller medication used at home: _____ <input type="checkbox"/> If temperature is below _____ degrees F, student should stay inside.</p>
IF YOU SEE THIS:	DO THIS:
<p>GREEN ZONE: No Symptoms Present</p> <ul style="list-style-type: none"> - No current symptoms - Doing usual activity 	<p>Pretreat strenuous activity: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Student/Parent request</p> <p>Give QUICK RELIEF MED _____ minutes before activity</p> <p>Number of puffs: _____</p> <p><input type="checkbox"/> Repeat in _____ hours, if needed, for additional physical activity.</p>
<p>YELLOW ZONE: Mild Symptoms</p> <ul style="list-style-type: none"> - Trouble breathing - Wheezing - Frequent cough - Complains of tight chest - Not able to do activities, talking in complete sentences - Peak flow: _____ - _____ 	<ol style="list-style-type: none"> 1. Stop physical activity 2. Give QUICK RELIEF MED: Number of puffs: _____ Frequency: Q _____ HRS 3. Stay with student and maintain sitting position 4. REPEAT QUICK RELIEF MED, if not improving in 10-15 minutes with <input type="checkbox"/> 2 puffs / <input type="checkbox"/> 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.
<p>RED ZONE: Severe Symptoms</p> <ul style="list-style-type: none"> - 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 < _____ 	<ol style="list-style-type: none"> 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: <input type="checkbox"/> 2 puffs or <input type="checkbox"/> 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, can carry and use his/her inhaler at school independently with approval from school nurse.
- 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 #