School Phone # _____
School Fax # _____

Symptom Based – Asthma Action Plan

Student Name: (please print) _____ Date of Birth: _____ School: _____

Parent/Guardian: (please print) _____ Home Phone: _____ Cell Phone: _____

The following is to be completed by the PHYSICIAN (Items #1, 2 ,3 , and 4):

1. **Medication(s)** (taken at school AND home): **Check box** if needed for use at school.

A. "QUICK—RELIEF" Medication Name	1.		☐ For school*
	2.		☐ For school*
B. ROUTINE Medication Name (eg: anti-inflammatory)	1.		☐ For school*
	2.		☐ For school*
C. BEFORE PE, Exertion: Medication Name	1.		☐ For school*
	2.		☐ For school*

2. **For student on inhaled medication** (all students must go to Health Office for oral medications)
   ☐ Assist student with inhaled medication in Health Office*
   ☐ May self-administer/self-carry inhaler medication.* Student demonstrates competence. (**Not** recommended in elementary school)
3. **Use of a spacer device** (**e.g. Aerochamber**) is advised for all students at school.
4. **Check known triggers**: ☐ tobacco ☐pesticides ☐ animals ☐ birds ☐cockroaches ☐cleansers ☐ car exhaust ☐perfume ☐candles ☐mold ☐dust ☐cold air ☐exercise ☐smog ☐pollens ☐ other _____
5. **Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:**

Symptoms:

GREEN ZONE

Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities.

YELLOW ZONE

Symptoms: Starting to cough, wheeze, feels short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions.

Action for School

1. Give "Quick—Relief" medication(s)*
2. Notify Parent if symptoms are NOT relieved by medication after 15-20 min
3. If Symptoms are NOT RELIEVED follow **School Emergency Plan** below
4. If symptoms are relieved, student may return to class.

**Notify Parent if "Quick—Relief" inhaler has been used more than two times this week (if not related to physical activity)*

RED ZONE

Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restricts, symptoms are the same or worse after **30 minutes in Yellow Zone**.

Action for School

1. Give "Quick—Relief" Medication(s)
2. If Symptoms are not improved within 15 to 20 minutes by student's "Quick—Relief" medication, or symptoms become worse, follow **School Emergency Plan** below.

SCHOOL EMERGENCY PLAN

1. ***REPEAT*** "Quick—Relief" medication(s) now
2. **Call 911** – Seek emergency care
3. Contact parent/guardian and school nurse.
4. REPEAT "Quick—Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved.
5. Stay with student until paramedics arrive.

Print Physician Name: _____ **Physician Signature:** _____ **Date:** _____
Address: _____ **Phone:** _____ **Fax:** _____
City: _____ **Zip:** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ Date: _____ Phone: _____

***Medication Administration Form required**, for meds taken at school.

Orange County Department of Education
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____
School/District: _____ Teachers Name: _____Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.

Revised 11/15/12

Orange County Department of Education
Instructional Services

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student**: _____*

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 11/15/12

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR NEBULIZER TREATMENT

Name of Student: _____ Birth date: _____ Grade/Track: _____

School/District: _____ Teachers Name: _____

Physical condition for which treatment is to be given: _____

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that the treatment stated below be administered to my child in accordance as ordered by the authorized health care provider. I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or prescribing authorized health care provider. I give permission for the school nurse to exchange treatment related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the treatment and its possible reactions.

Parent/Guardian Signature:_____ Date: _____

Telephone: (Work) _____ (Home) _____ (Other) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR **NEBULIZER TREATMENT**

Nebulizer Treatment requested during school hours: **( ) Yes ( ) No**
Diagnosis/Reason for Medication:_____
Medication: _____ Dose: _____ Route: _____ Time: _____
Medication:_____ Dose: _____ Route: _____ Time: _____
Time schedule and/or indication:_____
If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.
Precautions, possible untoward reactions, and recommend intervention(s): _____
_____

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed:

( ) a. Implement the treatment using nursing practice standards.
( ) b. Implement the treatment using nursing practice standards along with my modifications.
( ) c. Implement the treatment using nursing practice standards along with my attached recommendations.

Modifications:_____

Authorized Health Care Provider Signature: _____

Telephone: _____

Date of Request: _____

Date to Discontinue Treatment: _____

Office Stamp

SCHOOL USE:
Reviewed by:_____ Date: _____

_____ Date: _____

This request is valid for a maximum of one year.

Revised: 4/05 DR