Student Name_____ **Date of Birth:**_____
School/Teacher_____

ASTHMA ACTION PLAN

****

PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

****

Student Name: _____
Father's Name:_____ Home Phone:_____
Cell Phone: _____ Work Phone:_____
Mother's Name:_____ Home Phone:_____
Cell Phone: _____ Work Phone:_____
Emergency Contact if parent not available:_____
(Authorized to act in behalf of parents if we are unable to contact parent)
Home Phone:_____ Cell: _____ Work Phone:_____

Physician Name:_____ Phone:_____ Fax:_____

Please describe brief history of previous episodes of asthma. Describe frequency of episodes, symptoms and treatment that was required for the reaction(s).

_____
_____
_____

Please list all current medications taken at home:

_____
_____
_____

Name of Medication Dosage and Strength Purpose Days Given Time

ASTHMA INHALERS AND NEBULIZER MEDICATIONS FOR QUICK RELIEF OF ASTHMA SYMPTOMS ARE TO BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND AVAILABLE FOR THE STUDENT DURING SCHOOL AND ON FIELD TRIPS. STUDENTS WHO ARE COMPETENT TO SELF ADMINISTER (SEE PHYSICIAN ORDERS) MAY CARRY THEIR INHALER AT PARENT REQUEST.

IN THE EVENT THAT ASTHMA MEDICATIONS ARE NEEDED AND ARE NOT AVAILABLE, 911 WILL BE CALLED.

EXPIRED MEDICATIONS MUST BE REPLACED. EXPIRED MEDICATIONS CANNOT BE ADMINISTERED BY THE SCHOOL NURSE OR OTHER TRAINED ASSISTIVE PERSONNEL.

ALL MEDICATIONS SHOULD BE PICKED UP BY A PARENT/GUARDIAN AT THE END OF THE SCHOOL YEAR. MEDICATIONS WHICH ARE NOT PICKED UP WILL BE DISCARDED ACCORDING TO STATE REGULATIONS.

I understand that health information regarding my child will be kept confidential, but shared with school staff on a need to know basis in order to protect the health and safety of my child during the school day.
I understand that my child is competent to self-administer his/her medications with assistance from the school nurse or other designated, trained employee. I release the Franklin Special School District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand my child will be administered medications and emergency treatment as indicated by the physician orders on other side of this form. This treatment will be administered even if a parent/guardian cannot be reached. The physician providing medication orders on the other side of this form has my permission to provide this and other information regarding my child's health to the school nurse, principal or designated assistive personnel. The school nurse has my permission to speak with my child's physician regarding this plan and related health issues.
I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher).

I agree that this individualized healthcare plan meets the needs of my child. I have received notice of my rights to a 504 review and understand that I may contact _____at my school to request a review in this regard.

Parent/Guardian Name	**Parent/Guardian Signature**	**Date**
Nurse Name	**Nurse Signature**	**Date**

Student Name_____ **Date of Birth:**_____
School/Teacher_____

Franklin Special School District Asthma Action Plan/Medication Order

****

SECTION BELOW TO BE COMPLETED BY STUDENT'S PHYSICIAN

****

TRIGGERS: (Check those which apply to this student)

_____ Exercise	____ Pollens/Seasonal Allergies	____ Cold Air/Weather changes
_____ Respiratory Illness	____ Cigarette Smoke	____ Animal dander: type: _____
_____ Emotional Stress	____ Dust, Dust Mites	____ Other: (Specify) _____

GREEN ZONE: **DOING WELL:** No cough, wheeze, chest tightness or shortness of breath and can do normal activities. **Continue home medications for long-term control**.

YELLOW ZONE: **ASTHMA IS GETTING WORSE:** Symptoms include cough, wheeze, chest tightness, shortness of breath, can do some, but not all, usual activities, waking at night due to asthma symptoms. **Add quick relief medications as ordered below.**

RED ZONE: **GET HELP IMMEDIATELY! CALL 911** if student has not responded to quick-relief medications and has trouble walking or talking due to shortness of breath, the lips or fingernails are gray or blue, the skin is sucked in around neck and ribs during breathing or the child does not respond normally. Notify parent and physician.

QUICK RELIEF MEDICATION ORDERS

Inhaler Medication: _____ **Dosage**: ___ puffs every ____ hours p.r.n. per inhalation.

_____ **Repeat dose if needed** in _____ minutes. If symptoms persist and do not return to GREEN ZONE, contact parent to seek additional medical care or proceed to RED ZONE orders if indicated by symptoms.

_____ **Asthma is exercise induced**. In addition to above p.r.n. doses, give _____ puffs _____ minutes prior to physical activity/gym.

Possible side effects of medication: _____

Quantity Provided/Received: _____ Medication Expiration Date: _____

Medication received by _____ Date_____

OR

Nebulizer Medication:_____ **Dosage**: _____ every ____ hours p.r.n. per nebulizer.

_____**Repeat dose if needed** in _____ minutes. . If symptoms persist and do not return to GREEN ZONE, contact parent to seek additional medical care or proceed to RED ZONE orders if indicated by symptoms.

Possible side effects: _____

Quantity Provided/Received _____ Medication Expiration Date: _____

Medication received by _____ Date_____

ADDITIONAL ORDERS FOR INHALED MEDICATIONS

_____ It is my professional opinion that this student is competent to **self-administer** his/her inhaled medication and should be allowed to carry his/her inhaler. Each dose is to be documented by the student or teacher and the documentation supplied to the school nurse on at least a weekly basis.

_____ It is my professional opinion that this student **receive assistance** with administration of inhaled medication by the school nurse or other designated, trained employee.

_____ Notify physician if rescue medication use exceeds ____ times/week as this may indicate poorly controlled asthma.

_____ Additional Orders (Specify): _____

PHYSICIAN NAME: _____ **PHONE:**_____
PHYSICIAN ADDRESS: _____ **FAX:**_____
PHYSICIAN SIGNATURE: _____ **DATE:**_____

NOTICE OF PARENT AND STUDENT RIGHTS AND PROCEDURAL SAFEGUARDS
SECTION 504, The Rehabilitation Act of 1973

The Rehabilitation Act of 1973, commonly referred to as Section 504, is a federal nondiscrimination statute. The purpose of the Act is to prohibit discrimination and to assure that disabled students have educational opportunities and benefits equal to those provided to nondisabled students.

An eligible student under Section 504 is a student who (a) has, (b) has record of having, or (c) is regarded as having a physical or mental impairment which substantially limits a major life activity such as learning, self-care, walking, seeing, hearing, speaking, breathing, working and performing manual tasks.

The purpose of this Notice is to delineate the rights assured by Section 504. The enabling regulations for Section 504 at 34 CFR Part 104, entitle students to the following rights:

1. Your child has the right to an appropriate education designed to meet his/her individual educational needs as adequately as the needs of nondisabled students are met. 34 CFR 104.33.
2. Your child has the right to free educational services except for those fees that are imposed on nondisabled students or their parents. Insurers and similar third parties are not relieved from an otherwise valid obligation to provide or pay for services provided to a disabled student. 34 CFR 104.33
3. Your child has a right to placement in the least restrictive environment. 34 CFR 104.34.
4. Your child has a right to facilities, services, and activities that are comparable to those provided for nondisabled students. 34 CFR 104.34
5. Your child has a right to an evaluation prior to an initial Section 504 placement and any subsequent change in placement. 34 CFR 104.35.
6. Testing and other evaluation procedures must conform with the requirement of 34 CFR 104.35 as to validation, administration, areas of evaluation, etc. The district shall consider information from a variety of sources, including aptitude and achievement tests, teacher recommendations, physical condition, social and cultural background, adaptive behaviour, physical or medical reports, student grades, progress reports, parent observations, anecdotal reports, and assessment scores. 34 CFR 104.35.
7. Placement decisions must be made by a group of persons (i.e. Section 504 Committee), including persons knowledgeable about your child, the meaning of the evaluation data, the placement options, and the legal requirements for least restrictive environment and comparable facilities. 34 CFR 104.35.
8. If eligible under Section 504, your child has a right to periodic reevaluations, generally every three years. 34 CFR 104.35.
9. You have the right to notice prior to any action by the district in regard to the identification evaluation, or placement of your child. 34 CFR 104.36.
10. You have the right to examine relevant records. 34 CFR 104.36.
11. You have the right to an impartial hearing with respect to the district's actions regarding your child's identification, evaluation, or educational placement, with opportunity for parental participation in the hearing and representation by an attorney. 34 CFR 104.36.
12. If you wish to challenge the actions of the district's Section 504 Committee in regard to your child's identification, evaluation, or educational placement, you should file a written request for a due process hearing with the district's Section 504 Coordinator, Annie Sawyers (507 New Highway 96, West, Franklin, TN 37064, Phone: 615-794-6624).
13. If you disagree with the decision of the impartial hearing officer, you have a right to a review of that decision by a court of competent jurisdiction. 34 CFR 104.36
14. You also have a right to file a complaint with the Office of Civil Rights. The address of the Regional Office, which covers Tennessee, is:

Office of Civil Rights
61 Forsythe Street, SW, Suite 19T70
Atlanta, GA 30323
(404) 562-6350