Faribault Public Schools Asthma Care Plan and Medication Authorization

Student Name: **DOB:**

Parent/Guardian 1: Phone: ( )

Parent/Guardian 2: Phone: ( )

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list):

Asthma Symptoms (list):

GREEN ZONE

Doing Well
Symptoms:
Breathing is good
No cough or wheeze
Can work and play
Sleeps well at night

Control Medicine(s):

Medicine	How much to take	When and how often to take	Take at
_____	_____	_____	☐ Home ☐ School
_____	_____	_____	☐ Home ☐ School

Physical Activity

☐ Use albuterol/levalbuterol _____puffs, 10-20 minutes before activity ☐ with all activity ☐ when the child feels they need it

Yellow Zone: Caution
Symptoms:
Some problems breathing
Cough, wheeze, or chest tight
Cold symptoms
Problems working or playing
Wake at night

Quick-relief Medicine(s) Use albuterol/levalbuterol _____puffs, every 4 hours as needed

☐ Continue Green Zone medicines

☐ Add _____

☐ Change to_____

The child should feel better within 20-60 minutes of the quick-relief treatment.

If the child is getting worse or is in the Yellow Zone for more than 24 hours follow the instructions for the RED ZONE and call the doctor right away!

RED ZONE: GET HELP NOW!
Symptoms:
Breathing is difficult
Cannot work or play
Getting worse instead of better
Medicine not helping

Take Quick-relief Medicine NOW!:

Use albuterol/levalbuterol _____puffs, _____(how frequently)

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath Lips or
- fingernails are blue
- Still in the red zone after 15 minutes

Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Health Care Provider

Name_____Date_____Phone (____)_____Signature_____

Parent/Guardian

I give permission for the medicine listed in the action plan to be administered in school by a nurse or other trained staff as appropriate.

I consent to communication between the prescribing health care provider and school health office staff as necessary for asthma management and administration of this medication.

Name_____Date_____Signature_____

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine **(student assessment on back of form)**

Asthma Self Carry Contract

This side to be completed by Faribault Public Schools Health Office Staff

Student Name _____ Date of Birth _____ Grade/Section _____

Student Asthma Medication Self-Administration Agreement

I agree to:

- ☐ Use correct inhaler technique (demonstrate to nurse)
- ☐ Not allow anyone else to use my medication
- ☐ Maintain a written record of when I use my medication at school (I will document in my _____)
- ☐ Store my medication in my _____(e.g. Purse, backpack, locker)
- ☐ Keep spare medication in the nurse's office
- ☐ Check-in with the nurse ___daily ___ weekly ___ monthly ___ other:_____
- ☐ te the time and day you plan to meet with the nurse_____
- ☐ Notify the school health office or _____ under the following circumstances:
  - ✓ I need to take my quick relief medication more than 2 times a week during the day or more than 2 times a month at night
  - ✓ I have asthma symptoms after exercise, sports, or physical education class
  - ✓ My symptoms don't go away or get worse after taking my medication
  - ✓ Other _____
- ☐ Follow my health care providers directions
- ☐ Refill my prescriptions before they run out (or help remind my parent/guardian to do so)
- ☐ See my health care provider for preventative "Well Asthma Check-ups" at least twice a year or as recommended by my provider
- ☐ Call my health care provider if I am having symptoms that don't get better after within 24 hours

Know or will find out:

- ☐ Who my health care provider is and how to contact her/him
- ☐ Where my pharmacy is and how to contact it

Student Signature_____**Date**_____

Health Office Assessment of Asthma Self- Administration and Self-Care Skill

- ☐ This student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell and adult if symptoms do not improve after taking the medicine.
- ☐ This student may self-carry and should check in with me as described above
- ☐ This student needs reinforcement of his/her asthma medication and self-care skills.
- ☐ I do not feel it is appropriate for them to self-administer at this time, parent will be notified and a plan created

Comments

_____

_____

Health Office Nurse Signature _____**Date**_____

If the Health Office Nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the nurse will contact the student's parent/guardian and health care provider and attempt to agree upon a plan. In the event agreement is not reached, the parent may refer the case to Faribault Public Schools District Health Coordinator at 507-333-6104 for resolution. Permission for self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement.

The Asthma Care Plan and Medication Authorization has been reviewed by school health office staff:

Name_____Date_____Signature_____

Name_____Date_____Signature_____