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GOOD SHEPHERD EPISCOPAL SCHOOL ASTHMA ACTION PLAN

Name_____ **D.O.B**_____ **Grade**_____ **School Year**_____ student picture

Doctor_____ **Doctor's Phone Number**_____

Will student keep inhaler with him/her in backpack/locker? ❑Yes ❑No. If yes, please provide back up for clinic.**

Emergency Contacts

	Name	Phone #	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

☺ **Green Zone** - No symptoms

❑No control medicines required OR

Oral control medication _____ taken _____ times a day at ❑home ❑school.

Inhaled medication(MDI)_____ puffs_____ taken_____ times a day at ❑home ❑school.

For asthma with exercise: _____ puff(s) of _____(MDI) taken _____minutes before exercise.

😐 **Yellow Zone** – Tight chest, cough or mild wheeze, signs of upper respiratory illness, unable to exercise (participate in P.E.)

❑Rescue Inhaler (take this medicine)

Inhaled medication(MDI)_____ 2 or 4 puffs every 20 minutes for up to 1 hour.

Continue monitoring to be sure student remains in Green Zone.

Or

If symptoms do not return to Green Zone after one hour of above treatment:

Inhaled medication (MDI) _____ 2 or 4 puffs and parent or emergency contacts will be called. **If student needs nebulizer treatments, parents or emergency contacts will be called to take student home.

☹ **Red Zone** – Medical Alert! Very short of breath, unable to talk, eat or walk well, breathing hard and fast, medicine is not helping, blue lips and or fingernails, chest and neck retractions. If rescue inhaled medications have not helped or symptoms are same or getting worse.

Inhaled medication (MDI) _____ 4 or 6 puffs and parent or emergency contacts will be called. **If student needs nebulizer treatments, parents or emergency contacts will be called to take student home.

If parent or emergency contacts cannot be reached, then 911/EMS will be called.

Physician's Consent for Self-Administration of Asthma Medication

I have instructed the student in the proper way to use his/her asthma medications. It is my professional opinion that this student ❑should/ ❑should not (check one) be allowed to carry and self-administer his/her medications while on school property or at school-related events. Physician's initials _____

Physician's Name_____ Phone Number_____

Physician's Signature_____Date_____

**Inhaler shall be current, if expired, student will be unable to use and parents must provide current inhaler immediately.

For Clinic Use Only:

____ Medication Received Date _____ _____ Medication Returned Date _____

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Background Information

Asthma Severity: ❑Mild ❑Moderate ❑Severe

Asthma Control: ❑Well-controlled ❑Needs better control

Asthma Triggers: ❑Colds ❑Pollen ❑Dust ❑Animals _____ ❑Smoke ❑Pests (rodents, cockroaches) ❑Stress ❑Exercise ❑Gastroesophageal reflux ❑Strong Odors ❑Seasonal_____ ❑Other_____

Has the student ever experienced a severe asthma episode in the past that required emergency room care or hospitalization? _____

What care was needed at that time?

_____

_____

Parent/Guardian Consent for Self-Administration of Asthma Medication

❑I do / ❑do not (check one) give consent for my child to carry and self-administer his/her asthma medications. If my child caries his/her own asthma medication, I realize that the school clinic will not have his/her personal asthma medication(s) unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s). However, I acknowledge that the school is relying on my representation that my child is adequately trained to identify symptoms and self-administer his/her asthma medication(s).

Parent initials _____

Parent/Guardian Consent for Unlicensed Personnel to Administer Asthma Medication

❑I do / ❑do not (check one) authorize Good Shepherd Episcopal School to designate unlicensed personnel who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer asthma medication(s) to my child while in attendance at Good Shepherd Episcopal School or related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein.

Parent initials _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless Good Shepherd Episcopal School for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Asthma Medication to the Student, the Student's self-administration of Asthma Medication and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against Good Shepherd Episcopal School for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of Asthma Medication to the student and/or Student's self-administration of Asthma Medication, or the disclosure of Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s) negligently failed to recognize symptoms requiring the use of Asthma Medication, misconstrued symptoms which it believed necessitated the use of Asthma Medication, negligently administered or failed to administer Asthma Medication(s), or "over-disclosed" my child's health information.

Parent initials _____

Parent Name _____ Phone_____

Parent Signature_____ Date_____