ASTHMA EMERGENCY ACTION PLAN
LAKE LOCAL SCHOOL DISTRICT

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

Usual signs of asthma *(check all that apply):*

☐ Wheezing ❑ Tightness in chest ❑ Coughing ❑ Difficulty breathing
☐ Difficulty speaking ❑ Other (please describe) _____

Triggers *(please check all things that are known to start an asthma episode):*

☐ Wheezing ❑ Respiratory infections ❑ Pollen ❑ Temperature changes
☐ Dust ❑ Other (please describe) _____

Does student measure peak flow at school on a daily basis? ❑ Yes ❑ No If yes, please fill in the Numbers for each range: GREEN: _____ YELLOW: _____ RED: _____

Daily Medication Plan

Name of Medication	Type (Inhaler, tablet, etc.)	Dosage/times	Will be used at school? **

Does student need assistance taking their medication? ❑ Yes ❑ No

**A completed and signed School Medication form for the administration of prescription medications must be on file at the school for each medication to be administered during the school day.

**If the student is to carry his/her asthma inhaler, a Self-Medication for Asthma Inhalers Authorization Form must be on file in the school office.

TREATMENT FOR ASTHMATIC EPISODE

- Make sure student sits down and tries to stay calm. Do not have student lie down.
- Check student's peak flow if part of daily routine for asthma control.
- Try giving student sips of clear liquids, preferably warm.
- Supervise the administration of any prescription medications – see medications listed above.
- Observe student closely for any change in condition. Allow student to return to class or normal activity if symptoms are relieved after using medication.

ASTHMA EMERGENCY PLAN

****Must be completed by physician if rescue medication(s) to be given at school.*

- If no improvement in symptoms within _____ minutes of using _____ , repeat Medication and notify parent/emergency contact from attached emergency medical form.
- Call 911 if: *(please check all that apply)*
  - ☐ No improvement in symptoms after second dose of medication
  - ☐ No improvement in symptoms and unable to reach parent
  - ☐ Peak flow of _____
  - ❑ Struggling or gasping while trying to breathe
  - ☐ Chest and neck pulling with breathing
  - ❑ Lips or fingernails are grey or blue
  - ☐ Other: _____

Comments/Special instructions: _____
_____

_____ _____ _____
Physician's Signature (required) *Physician's Printed Name* *Date*

_____ _____
Physician's Address *Physician's Phone Number in case of emergency*

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____ _____/_____/_____
Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

SELF-MEDICATION REQUEST FORM
(Asthma Inhalers)
LAKE LOCAL SCHOOL DISTRICT

Student Name _____ Building _____

School Year _____ Grade/Teacher _____ Date of Birth _____

Address _____

This portion to be completed by the physician or other prescribing health provider

Medication _____ Dosage _____ Time _____

Date administration of the medication is to begin: _____ end: _____

Adverse reactions that should be reported to the physician: _____

Procedure to follow in the event that the medication does not produce the expected response/relief:

This student received instruction in the use of this inhaler by myself or my trained staff. It is my recommendation that this student carry his/her inhaler on his/her person at all times.

Yes No (circle one)

Physician/Authorized Prescribing Healthcare Provider Signature *Phone in case of emergency* *Date*

Printed Name *Address* *Telephone in case of emergency*

This portion to be completed by the Parent/Guardian

I request that my child be permitted to carry his/her metered dose inhaler while at school and for school related activities. I realize that my child will be required to have his/her inhaler on his/her person in order to go on any field trips or other extracurricular events off campus. **A back up inhaler is to be kept in the school clinic.** This form is valid for the remainder of this school year or until the prescribing doctor or other authorized healthcare provider discontinues this prescription/dose.

Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*

File: JHCD-E
Attachment A

LAKE LOCAL SCHOOL DISTRICT

PRESCRIPTION Medication Request Form

Under provisions of the Ohio Revised Code, all public schools require the following information when children require administration of prescription drugs. Please complete the following information and return to the school.

Student Last Name	First	Middle
Student Address		

Building	School Year	Grade	Date of Birth

Name of Medication	Dosage/Administration Instructions
Administration of medication to BEGIN	Administration of medication to END
Significant side effect (adverse reactions) which should be reported to the physician:	
Special instructions for administration of the drug, include sterile conditions and storage:	

Physician's SIGNATURE	PRINT Physician's Name	Physician's EMERGENCY Phone Number

With full knowledge of any emergencies, dangers, and risks related to the administration of such medication by the Lake Local Schools employees, officers, or agents, we, the undersigned, hereby waive all claims which might arise from said administration of medication to said minor child. We hereby assume full responsibility for the administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Lake Local School District, Lake Local Board of Education, its members, offers, employees, and agents from any and all liability relative to the administration of such medication.

1. ***There must be <u>written</u> notification to the school if there is any change in the physician's medication order.***
2. ***Medication must be in the original container as dispensed by the physician or pharmacy.***
3. ***It is advised that the medication form and medication be brought to the school by the parent/guardian.***
4. ***The student must assume responsibility for presenting him or herself for the medication at the appropriate time.***
5. ***Parents hereby authorize school personnel to communicate with the pharmacist or physician to clarify order information and communicate student progress.***
6. ***It is the responsibility of the parent/guardian to retrieve any remaining medication at the end of the administration period (or school year). Any unclaimed medication will be disposed of prior to the next school year.***

_____ _____ _____/_____/_____

Parent/Guardian Signature | Date | Phone Numbers (Home/Work/Cell)