LAUREL PUBLIC SCHOOLS ASTHMA CARE PLAN AND ORDERS FOR SCHOOL

Student: _____ **DOB:**_____ **School:**_____ **Grade:** _____ **School Year:** _____
Asthma Triggers (List): _____
Severity Classification: ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent**

PARENT/GUARDIAN COMPLETE AND SIGN

Parent/Guardian Name(s): _____ **Phone Number(s):** _____
Health Care Provider: _____ **Phone Number:** _____

- I understand that this form is effective this school year and in summer school, if needed, and needs to be completed annually and updated with any changes during the school year.
- By signing this document, I give permission for this Health Care Provider to share information about this medication/procedure with the Registered Nurse.
- I assume full responsibility for providing the school with the prescribed medication and supplies necessary for treatment of my child's asthma. **I will complete the LPS MT Authorization to Carry & Self-Administer Asthma/Allergy Med Form if applicable.**
- I am aware that 911 may be called if my child's symptoms are severe and a quick relief inhaler is not available at school or if the plan has been followed and my child is not responding to treatment.
- I acknowledge that the school district may not incur liability as a result of any injury arising from the administration of medication and that the parent shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission, that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I approve of this plan for my child.

Parent/Guardian Signature: _____ **Date:** _____

HEALTH CARE PROVIDER ORDER

Please check: ❑ **Student needs supervision to use inhaler.** ❑ **Student understands the proper use of asthma medications and may administer the medication without direct supervision.**	**Quick Relief (Rescue) Medication:** _____ **Controller Medication used at home:** _____ ❑ **Spacer recommended (if available)**
IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: Doing Well • **No cough, wheeze, chest tightness, or shortness of breath during the day or night.** • **Can do usual activities.**	**Pretreat strenuous activity (PE, long recess, sports event, etc.):** ❑ **Not required** ❑ **Routine** ❑ **Per parent/student request** **Med/Dose/Time:**
YELLOW ZONE: Asthma is getting worse • **Frequent cough, wheezing, chest tightness, shortness of breath, and complains of difficulty breathing** • **Able to talk in complete sentences but not able to do activities.**	**1. Stop physical activity.** **2. Quick relief inhaler:** ❑ **2 puffs** ❑ **4 puffs** **3. Student should be monitored closely.** **4. If not improving in ___ minutes, repeat quick relief med:** ❑ **___ puffs every ___ minutes up to 1 hour** ***Notify parent/guardian and School Nurse if not already present.*** **5. May return to normal activities once symptoms are relieved.** ***IF SYMPTOMS DO NOT IMPROVE OR WORSEN FOLLOW "RED ZONE"**
RED ZONE: Emergency! • **Coughing constantly, struggling to breathe, skin of chest and/or neck pull in with breathing, lips/fingernails gray or blue, and/or decreased level of consciousness** • **Difficulty talking (only speaks 3-5 words) and unable to do usual activities.**	**1. Quick relief inhaler:** ❑ **4 puffs** ❑ **6 puffs** **2. Call 911** **3. Call parent/guardian and School Nurse if not already present.** **4. Stay with student- remain calm and encourage slow, deep breaths** **5. If symptoms not improving or continuing to worsen, repeat quick relief inhaler dose _____ puffs every _____ minutes until symptoms improve or EMS arrives.**

Other instructions for this student: _____

Health Care Provider Signature: _____ **Date:** _____