SAYRE SCHOOL
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Asthma Action Plan

2022-2023 School Year

Parents must complete and submit the Asthma Action Plan annually in order to authorize Sayre School personnel to treat the student if needed during school hours.

Student Information:

Name: _____ DOB: _____ Grade: _____

Allergies: _____

Parent/Guardian names and cell phone numbers: _____

_____

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Allergy Triggers:

☐ Pollen ☐ Exercise ☐ Dust Mites ☐ Smoke ☐ Weather ☐ Food
☐ Cold/Flu ☐ Animals ☐ Air Pollution ☐ Other: _____

Asthma Severity Classification:

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Exercise Pre-Treatment:

☐ Not required ☐ Before recess:
Medication: _____
Timing: _____
Dosage: _____

☐ Before PE/sports:
Medication: _____
Timing: _____
Dosage: _____

If asthma is well-controlled (breathing is easy, no cough or wheeze, and student can do usual activities):

Medication	Route	Dosage	Times to be given

Please continue to next page.

If asthma is worsening (some shortness of breath, cough, wheeze, or chest tightness, some difficulty doing usual activities, sleep disturbed by symptoms, or symptoms of cold or flu)

Medication	Route	Dosage	Times to be given

If symptoms have worsened, indicating an emergency (severe breathing problems, chest and neck pulled in with each breath, cannot do usual activities, difficulty walking or talking, rescue medication are not improving symptoms):

Actions:

Continue asthma medications and do the following:

___ puffs of albuterol/Xopenex every _____ minutes for a total of _____ doses

Call doctor now! If they cannot be reached, call 911 or go directly to the emergency room.

☐ If checked, student will self-carry inhaler. The student is capable and has been instructed in the proper method of self-administering medications named above. All students are encouraged to provide an additional inhaler that will be stored in a locked cabinet in the nurse's office.

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

The above orders are valid for one year from the date signed by the physician.

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without the medication.

Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, afterschool, and at bedtime. If a new medication is started, the first dose must be given at home, unless it is a rescue medication.

The school will adhere to the following guidelines as it pertains to medication:

- Administration of prescription medication by school personnel must only be done according to the written order of a licensed prescriber and written authorization of parent / guardian and Licensed School Nurse, regardless of the student's age.
    - Mixed dosages in a single container will not be accepted for administration at school.
    - If a half tablet is required for a correct dosage, it is the parent's / guardian's responsibility to provide pre-cut tablets for administration at school.
    - Altered forms of medication will not be accepted or administered at school.
    - Narcotics / medical cannabis will not be administered at school.
    - Aspirin-containing products will not be administered at school.
    - Only FDA approved treatments will be provided at school. (No essential oils)

- All medication (prescription and non-prescription) must be brought to and from school by a parent / guardian in its original container. The following information must be on the prescribed container label:
    - Student's full name
    - Name and dosage of medication
    - Time and directions for administration at school
    - Physician / licensed prescriber's name
    - Date (must be current)

- New consent from a licensed health care provider and parent / guardian signatures must be received each school year.

- A new medication consent form is required when the medication dosage or time of administration is changed.

- When a long-term daily medication is stopped, a written physician / licensed prescriber's order is requested.

- Medication will be kept in a locked cabinet in the Nurse's Office unless authorized by the Licensed School Nurse, and must not be carried by the student.

PARENT/GUARDIAN AUTHORIZATION

- I request the medication(s) listed on page one be given to my child during regular school hours as ordered by the physician/licensed prescriber. (Note: This does not pertain to after-school activities.)
- I give permission for the medication to be given by designated personnel.
- For prescription medication, I will provide the above-mentioned medication in the pharmacy labeled container.
- I authorize the Licensed School Nurse or designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.
- I authorize the Licensed School Nurse or designee to communicate with appropriate school personnel regarding this medication for my child.
- I release Sayre School and school personnel from any liability in relation to the administration of this medication.
- I have read and understand the Medication Guidelines included in this form.

Parent Name: _____

Parent Signature: _____ Date: _____