Virginia Asthma Action Plan

Appendix F-3A

School Division:

Name			Date of Birth
Health Care Provider	Provider's Phone #	Fax #	Last flu shot
Parent/Guardian	Parent/Guardian Phone		Parent/Guardian Email:
Additional Emergency Contact	Contact Phone		Contact Email

Asthma Triggers (Things that make your asthma worse)

☐ Colds	☐ Dust	☐ Animals:_____	☐ Strong odors	Season
☐ Smoke (tobacco, incense)	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/moisture	☐ Fall ☐ Spring
☐ Pollen	☐ Exercise	☐ Other:_____	☐ Stress/Emotions	☐ Winter ☐ Summer

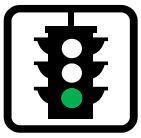
▼ Medical provider complete from here down ▼

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

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow: _____

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ Aerospan_____ ☐ Advair _____ ☐ Alvesco _____ ☐ Asmanex _____ ☐ Budesonide _____

☐ Dulera _____ ☐ Flovent _____ ☐ Pulmicort _____ ☐ QVAR _____ ☐ Symbicort _____

☐ Other :_____

____ puff (s) MDI ____ times a day **Or** ____ nebulizer treatment(s) ____times a day

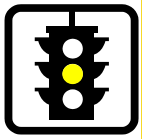
☐ (Montelukast) Singulair, take _____ by mouth once daily at bedtime

For asthma with exercise, ADD: ☐ Albuterol ☐ Xopenex ☐ Ipratropium, **MDI, 2** puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing



Peak flow: _____ to _____
(60% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent), **MDI,** ____ puffs with spacer every ____hours as needed

☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5mg/3ml
one nebulizer treatment every____ hours as needed

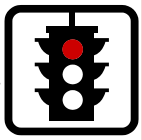
☐ Other :_____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show



Peak flow: < _____
(Less than 60% of Personal Best)

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent), **MDI,** ____ puffs with spacer **every 15 minutes**, for **THREE** treatments.

☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5mg/3ml
one nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other : _____

Call your doctor while administering the treatments.

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN_____ **Date** _____

SCHOOL NURSE/DESIGNEE_____ **Date** _____

OTHER_____ **Date** _____

CC: ☐ **Principal** ☐ **Cafeteria Mgr** ☐ **Bus Driver/Transportation** ☐ **School Staff** ☐ **Coach/PE** ☐ **Office Staff** ☐ **Parent/guardian**

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

Check One:

☐ Student, in my opinion, can carry and self-administer inhaler at school.

☐ Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.

MD/NP/PA SIGNATURE:_____ **DATE** _____

Effective Dates ▶ _____ **to ▶** _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015

Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, and District of Columbia Asthma Partnership

Office of Catholic Schools
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Appendix F-3

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
INHALED MEDICATION or NEBULIZER TREATMENT AUTHORIZATION

Release and indemnification agreement -- **PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE**

PART 1 TO BE COMPLETED BY PARENT

I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Inhaler/Respiratory Treatment □ Renewal □ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date_____ Time_____

Student Name (Last, First, Middle)	Date of Birth
Allergies	School: **Our Lady of Good Counsel** / School Year: **2022-2023**

_____ Parent or Guardian Signature

_____ Daytime Telephone

_____ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)

DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS	MEDICATION AND ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL	INTERVAL FOR REPEATING DOSAGE:
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which inhalers and/or respiratory treatments are to be taken:

Check ✓ the appropriate boxes:

☐ I believe that this student has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

The student ☐ is to ☐ is NOT to carry an inhaler during school and school sanctioned events with principal approval.

☐ Asthma Action Plan is attached (if appropriate).

_____ Licensed Health Care Provider (Print)

_____ Licensed Health Care Provider (Signature)

_____ Telephone or Fax

_____ Date

_____ Parent or Guardian

_____ Parent or Guardian Signature

_____ Telephone

_____ Date

_____ Student Signature (Required if student carries inhaler)

_____ Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

☐ Inhaler/Respiratory Treatment Medication is appropriately labeled.

Date by which any unused inhaler/respiratory treatment medications and/or supplies is to be collected by the parent (within one week after expiration of the physician order or on the last day of school). _____

☐ I have reviewed the proper use of the inhaler with the student and, ☐ agree ☐ disagree, that student should self carry in school.

_____ Signature

_____ Date

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
ANTIHISTAMINE AUTHORIZATION

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Medication □ Renewal □ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date_____ Time_____

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer medication or treatment, unless the principal has reviewed all the required clearances.

_____ _____ _____

Parent or Guardian Signature | Daytime Telephone | Date

PART Il TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS

The school discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

ALLERGIC REACTION TO: EXPOSURE- INGESTION □ CONTACT □ INHALATION □ STING □	SIGNS / SYMPTOMS:
MEDICATION:	ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL:	TIMES OR INTERVAL TO BE GIVEN:

EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which medications are to be taken

COMMON SIDE EFFECTS:

_____ _____ _____ _____

Licensed Health Care Provider (Print or Type) | Licensed Health Care Provider (Signature) | Telephone or Fax | Date

_____ _____ _____ _____

Parent or Guardian Name (Print or Type) | Parent or Guardian (Signature) | Telephone | Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

□ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

□ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent (Within one week after expiration of the physician order or on the last day of school).

_____ _____

Signature | Date

Revised 2016

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order

10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)

14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.