ST. MARY'S COUNTY PUBLIC SCHOOLS
Department of Student Services
*ASTHMA EMERGENCY ACTION PLAN **AND** MEDICATION ORDERS*

This order is valid only for the _____ (current) school year and summer session.

Student Name:	DOB:	Date Initiated:
Teacher:	Grade:	School:

Asthma Severity: ☐ **Exercise Induced** ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent**

Student-specific triggers include: _____

BUS INFORMATION

Bus # to school: _____ Bus # from school: _____ Additional Bus #'s: _____

Emergency actions while the student is on the bus:

☐ Follow the emergency action plan below.

☐ Other: _____

GREEN ZONE – Doing Well – No Actions Are Needed

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities
- Peak flow: more than _____ (80 percent or more of my best peak flow). My best peak flow is: _____.

Medication	Dose/Route	Frequency/Time	Used in School
			☐
			☐
Before exercise			
Medication	Dose/Route	Frequency/Time	Used in School
		_____ minutes before exercise with a minimum of _____ hours between doses	☐

If a student-specific rescue medication is NOT available, but SMCPS stock albuterol inhaler IS available:

☐ **Pre-Kindergarten** - use **ONLY** if the student has an active asthma rescue medication school order **AND** the student's medication is **NOT** available.

☐ **Kindergarten - 12th Grade** - use the SMCPS stock albuterol inhaler

YELLOW ZONE – ASTHMA IS GETTING WORSE – Use Rescue Medication(s), Notify the school nurse (if available), call parent/guardian

- Cough, wheeze, chest tightness, shortness of breath
- Cough at night
- Can do some, but not all, usual activities
- Other: _____
- Peak flow: _____ to _____ (50 to 79 percent of my best peak flow)

Medication	Dose/Route	Frequency/Time	Used in School
			☐
			☐

RED ZONE – MEDICAL EMERGENCY – Continue Rescue Medication(s) and CALL 911. Notify the school nurse, if available, call parent/guardian after calling 911

- Rescue Medication is not helping within 15-20 minutes of the student receiving it.
- Symptoms are getting worse (i.e., breathing is hard and fast or difficult, widening of the nostrils while breathing, pulling in of muscles of neck or chest, lips or fingernails blue, trouble walking, inability to speak in full sentences without taking a breath)
- Cannot do usual activities
- Other: _____
- Peak flow: _____ (less than 50% personal best)

Medication	Dose/Route	Frequency/Time	Used in School
			☐
			☐

STUDENT'S ORDERED EMERGENCY MEDICATIONS FOR SCHOOL

Emergency Medication: ☐ Yes ☐ No Self-Carry ☐ Yes ☐ No

Name of Emergency Medication:

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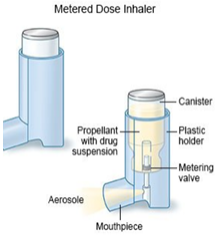
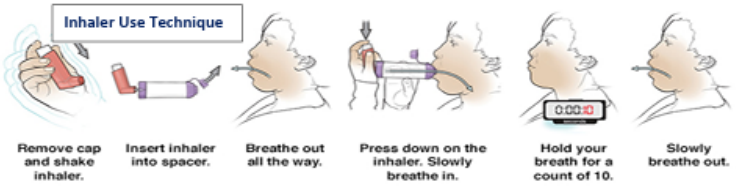
Location of Emergency Medication:
Additional Medication/Procedure Notes:

CONTACT INFORMATION	
Parent/Guardian #1:	Parent/Guardian #2:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Emergency Contact:	Phone:

HOW TO USE A METERED-DOSE INHALER



1. Take off the cap. Shake the inhaler.
2. Prime the inhaler by spraying one dose into the air, pointing away from people.
3. Use a spacer if available. If a spacer is used, put the inhaler on the end of the spacer.
4. Have the student stand up or sit up straight.
5. Instruct the student to breathe out completely to empty the lungs.
6. Instruct the student to place the mouthpiece in their mouth and close lips OR use the mask if provided and form a tight seal.
7. As the student starts to breathe in, instruct them to press down firmly on the top of the medicine canister to release one "puff" of medicine. Continue to breathe in slowly for 3 to 5 seconds. Taking as big a breath as possible.
8. Have the student hold their breath and count to 10.
9. Instruct the student to take the mouthpiece out and release their breath.
10. If the action plan says to take more than 1 puff of medicine, wait 30–60 seconds between puffs. Repeat steps 3 through 8 for each puff needed.
11. Clean inhaler.



Adapted from the NIH- National Heart, Lung and Blood Institute

Prescriber Authorization

I authorize the administration of the medications as ordered above.
It has been determined this student is able to self-administer and carry emergency medication and has been trained in its use. ☐ Yes ☐ No
Relevant Side Effects: None Expected Specify: _____
Health Care Provider Name: _____ Telephone:_____ Fax: _____
Address: _____
Prescriber's Signature: _____ Date:_____

Parent(s)/Legal Guardian(s) Authorization/Approval

I/We request designated school personnel to administer the medication as prescribed by the prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that it is my/our responsibility to furnish this medication. I/We further understand that any school employee who administers any drug to my/our child, in accordance with written instructions from the prescriber and St. Mary's County Public Schools, shall not be liable for damages as a result of an adverse drug reaction suffered by my/our child due to the administration of the drug. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

I acknowledge that my child ☐ is ☐ is not authorized to self-carry his/her medication(s).

Parent(s)'/Legal Guardian(s) Signature: _____ Date: _____
Note: When this form is complete and signed by the physician and parent(s)/legal guardian(s), return it to the school nurse at your child's school along with the prescribed medication in the original pharmacy container. Thank you.

Reviewed by School Nurse

Name: _____ Signature: _____ Date: _____

School RN approval for self-carry/self-administration of emergency medication: ☐ Yes ☐ No
Note: A non-nursing person may administer medication(s). If possible, arrange time of dosage so that medication(s) will not have to be given

while the child is in school. School hours vary with each school.
Student Name: _____ D.O.B._____

Emergency Action Plan (EAP) was reviewed by the following staff, and applicable training was provided. Training included:			
Date	Name	Job Title/Position	School Nurse Signature