ASTHMA
Emergency Care and Individual Health Plan

☐ 504 Accommodation Plan ☐ IEP

No Image Available

Student Name:		DOB:
School:	School Year	Grade:
Transportation ☐ Walker ☐ Car ☐ Bus Rider - Bus Number:		Advisor:
Inhaler stored: ☐ With Student ☐ Health Room ☐ Class ☐ Coach ☐ Other:		
Allergies ☐ YES (High Risk for Severe Reaction) ☐ No Allergies to:		

MEDICATION ORDERS

This section to be completed by a LICENSED HEALTHCARE PROVIDER (HCP)

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Control Level ☐ Well controlled ☐ Not Well Controlled ☐ Very Poorly Controlled ☐ Other:

☐ **Yes** ☐ **No** **This is a life-threatening condition for this student that requires medication and a care plan at school prior to attending school safely per RCW 28A.210.320.**

Medication	☐ Albuterol (Pro-Air, Ventolin, Proventil)	☐ Levalbuterol (Xopenex)	☐ Other:
Dose	☐ 2 puffs by mouth	☐ 4 puffs by mouth	☐ Other:
Time	☐ As needed every ☐ two hours ☐ four hours ☐ six hours for cough, wheeze or shortness of breath		
	☐ May repeat after _____ minutes if no relief from first dose		
	☐ _____ minutes before PE or other strenuous exercise	☐ as needed	☐ scheduled
	☐ Other:		
Side Effects	Increased heart rate, shakiness, other:		

☐ **Yes** ☐ **No** **It is medically necessary for this student to carry an inhaler during school hours. Student has demonstrated correct inhaler use to HCP and may carry and self-administer inhaler.**

Medication orders and treatment plan expiration date: ☐ End of current school year ☐ Other:

Healthcare Provider's **Signature:**		☐ Signature on File	Date: _____
Healthcare Provider's Name:		HCP Phone:	HCP Fax:

EMERGENCY PLAN

(Not all students will experience all symptoms during an asthma attack)

YELLOW ZONE - CAUTION	**Immediate Responses** to any symptoms
Some problems breathing	Stop activity and accompany student to health room **(do not send alone)**
Cough, mild wheeze or tight chest	Give medication as prescribed
Shortness of breath	Keep student sitting up
Problems working or playing	Encourage relaxation, deep slow breaths and sips of warm water
	Stay with student until improvement noted
Peak Flow to	Notify school nurse and parent if inhaler repeated

RED ZONE - GET HELP NOW for any of these symptoms	Immediate Responses - in order
Breathing is hard and fast	**Call 911**
Trouble walking or talking due to shortness of breath	Notify Parent
Nose opens wide or ribs show	Notify School Nurse
Getting worse instead of better	Notify School Principal
Rescue inhaler is not helping	**Always Stay with Student**

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Student Name | Grade

MEDICAL INFORMATION

This section to be completed by parents/guardians

Asthma Maintenance Medication:

When was this student's asthma first diagnosed?

How many times in the last year was this student seen in the Emergency Room or hospitalized?

Triggers	☐ Exercise	☐ Illness	☐ Strong Odors	☐ Dust	☐ Food:	☐ Medication:
	☐ Pollen	☐ Mold	☐ Cigarette Smoke	☐ Stress	☐ Animals:	☐ Other:

Usual Symptoms ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asks to use inhaler ☐ Other:

OTHER ACCOMMODATIONS - MODIFICATIONS

PARENT/GUARDIAN INFORMATION

Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

EMERGENCY CONTACT INFORMATION

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

PARENT/GUARDIAN CONSENT - You must complete and SIGN

☐ I request that authorized school personnel assist my child to take the medicine(s) described above. (If no box is checked, this option is the default.)

☐ I request that my child be permitted to self-administer the medicine(s) described above. I will hold harmless and indemnify the District, its officers, employees and personnel against all claims or liability arising out of the student's self-administration or carrying of medication.

☐ I am at least 18 years old and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130).

My signature indicates my permission for the exchange of information between school staff and the health care provider, and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law. I understand that if this is a plan for a life threatening condition it can only be discontinued, in writing, by a health care provider.

The permission to possess and self-administer medication may be revoked by the principal or school nurse if it is determined that your child is not safely and effectively possessing and self-administering medication.

**** It is strongly recommended that extra medication be provided and stored in the school clinic.****

Parent Signature: ☐ Parent/Guardian Signature on File Date:

School Nurse and Administrator - Complete this section.

Student has demonstrated to the school nurse the skill necessary to use the medication and any device necessary to self-administer the medication.	☐ Yes ☐ No
Student has permission from administrator to carry and self-administer medications approved by licensed healthcare provider.	☐ Yes ☐ No

School Nurse:		☐ Nurse's Signature on File	Date:	
Administrator:		☐ Administrator's Signature on File	Date:	

A copy of this plan is available in Skyward and will be kept in the school health room and shared with:

☐ Teachers ☐ Cook ☐ Nutrition Services ☐ Transportation ☐ Other