ISSAQUAH SCHOOL DISTRICT 411

☐ ASTHMA / ☐ RAD
Emergency Care Plan / 504

Student Name:	DOB:	
School:	School Year:	Grade:
Advisor	Transportation: ☐ Walker ☐ Car ☐ Bus Rider – Bus number:	

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)

☐ **Yes** ☐ **No** **This is a <u>life-threatening</u> condition for this student that <u>requires</u> 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 ☐ four ☐ six hours for cough, wheeze of 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 Effect: Increased heart rate, shakiness, other:

☐ **Yes** ☐ **No** **Is it medically necessary for this student to <u>carry</u> an inhaler during school hours?**

☐ **Yes** ☐ **No** **Student has demonstrated correct inhaler use to HCP and may carry and <u>self-administer</u> inhaler.**

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

Healthcare Provider's **Signature**: _____ Date:_____

Healthcare Provider's Printed Name: _____ Phone#:_____
Fax#:_____

EMERGENCY PLAN

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

Moderate Symptoms	Immediate Response
• Excessive Coughing • Wheezing • Shortness of Breath • Chest tightness • Nostrils flaring • Shoulders hunched over • Anxious or scared (Not all students will experience all symptoms during an asthma attack.)	• Accompany student to health room (Do Not Send Alone) • Give medication as prescribed by LTHCP • Guide student to inhale medication slowly & fully • Keep student sitting up and reassure student • Encourage to relax and take deep slow breaths • Stay with student until improvement noted • Contact school nurse or parent if no improvement after 15-20 minutes.
Severe Symptoms	**Immediate Response**
• Lips or nail beds turning gray or blue, paling of lips or nail beds. • Grunting • Inability to speak in complete sentences without taking a breath • Severe restlessness • Decreasing or loss of consciousness	• ***CALL 911*** • Notify Parent • Notify School Nurse • Notify School Principal • Do not leave the student unattended.

ASTHMA Emergency Care Plan/504

Student Name: **Grade:**

MEDICAL INFORMATION

This section to be completed by parents/guardian

Asthma History:	☐ On daily asthma medication – Daily medication: _____ ☐ Hospitalized overnight for asthma in past 3 years. ☐ Intubated for asthma attack. ☐ Oral steroids for asthma in past 6 months. ☐ Asthma related ER visit in past year.		
Usual Symptoms:	☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asks to use inhaler ☐ Other:		
Triggers:	☐ Exercise ☐ Pollen ☐ Illness ☐ Mold ☐ Strong Odors	☐ Cigarette Smoke ☐ Dust ☐ Stress ☐ Food ☐ Animals	☐ Medication ☐ Other:

EMERGENCY CONTACTS

Name	Phone	Relationship
1.		
2.		
3.		

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 of 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).

☐ I consent to the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student Rights.

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 healthcare provider.

The permission to possess and self-administer medication may be revoked by the 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 heath room.

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

School Nurse – 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

School Nurse: **Date:**

A copy of this plan is available in Skyward and will be kept in the school health room and copies will be given to:

☐ Teachers/Specialists ☐ Transportation ☐ Coach ☐ Other: