For _____ School Year (expires at the end of August)

SHORELINE SCHOOL DISTRICT
PROVIDER TREATMENT PLAN AND MEDICATION ORDER FOR ASTHMA

Note: These orders *must* be renewed every year, before the beginning of each school year

Shorewood High School 17300 Fremont Ave N Shoreline WA 98133	**ATTENTION: School Nurse** PHONE: 206-393-4386 FAX: 206-393-4711

Student Name: _____Birth date _____ Grade/Grad Yr._____

Licensed Healthcare Provider* _____ Phone_____ Fax _____

SCHOOL MEDICATION ORDERS – TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER*

Health condition requiring administration of medication (***Please circle***): Asthma Other _____

Medication: _____ Dosage: _____ Route: _____ Time: _____

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Possible side effects: _____

PLEASE COMPLETE ASTHMA TREATMENT PLAN BELOW – required for self-carry/self-administration

An alternative Asthma Treatment Plan can be substituted, but school medication orders MUST be included

GREEN ZONE: No coughing, no wheezing, breathing is unlabored

Controller medications to be used at home: _____

☐ **STUDENT NEEDS EXERCISE PRE-TREATMENT PRIOR TO STRENUOUS PHYSICAL ACTIVITY:**

1. Give _____ PUFFS quick-relief inhaler listed above _____ minutes prior to strenuous physical activity
2. Other instructions: _____

YELLOW ZONE: Mild/moderate symptoms (cough, wheeze, chest tightness, difficulty breathing)

1. Give _____ PUFFS quick-relief inhaler listed above
2. Restrict strenuous physical activity until symptoms improve
3. If symptoms do not improve or are getting worse, repeat dose after _____ minutes
4. If symptoms do not improve after repeated dose or are getting worse (medication is not working) GO TO RED ZONE instructions

RED ZONE: Severe symptoms (*very short of breath, continuous coughing, ribs visible during breathing, trouble walking or talking, lips or nails turning pale or blue, not responding to medication)*

CALL 911 AND PARENT/GUARDIAN. DO NOT LEAVE STUDENT UNATTENDED

1. Give _____ PUFFS quick-relief inhaler listed above
2. If symptoms do not improve or are getting worse, repeat dose after _____ minutes
3. **Give no more than a total of _____ PUFFS of quick relief inhaler in one hour**

Other instructions for this student: _____

Student may carry quick-relief inhaler in backpack: ☐ YES ☐ NO

Student may self-administer quick-relief inhaler: ☐ YES ☐ NO

Student has demonstrated use to Licensed Healthcare Provider* ☐ YES ☐ NO

Per RCW 28.A.210.370 "Students with Asthma", students must have a written treatment plan and must demonstrate the proper use of medication prior to being granted the ability to self-administer medication at school.

Parent/Guardian AND Licensed Healthcare Provider MUST COMPLETE PAGE 2 →

*MD, DO, ARNP, PA, ND

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

I request and authorize that the above-named student be administered the above-identified medication as per the instructions/treatment plan indicated above from the [dates] _____ to _____ [not to exceed the current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____ _____

Licensed Healthcare Provider* Signature **Date** **Phone**

TO BE COMPLETED BY PARENT/GUARDIAN

PARENT/GUARDIAN REQUEST: I request that the school nurse, or designated staff member, administer the medication(s) described above as directed by the above Licensed Healthcare Provider. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.
I give my consent for the confidential information contained on this form to be faxed to the above-named school.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (print)

_____ _____
Address Phone

SCHOOL NURSE USE ONLY
Inhaler to be stored: ☐ With student (backpack) ☐ Health Office ☐Other:

*MD, DO, ARNP, PA, ND

Updated 5/2021