



HILLVIEW ELEMENTARY SCHOOL
GROVE CITY
AREA SCHOOL
DISTRICT

MRS. TAMMI MARTIN
PRINCIPAL

MR. KEVIN PERSCH
ASSISTANT PRINCIPAL

MRS. REBECCA TRINCHESE
GUIDANCE COUNSELOR

Dear Parent/Guardian:

We are concerned about the safety and well-being of the students who have been identified as having asthma. It is important that they have access to the necessary medication for controlling symptoms of asthma as quickly as possible.

The Pennsylvania General Assembly passed a law requiring that schools have a policy to allow students to carry their inhalers with them. The Grove City Area School District has written such a policy as well. **I have attached a prescription form/action plan which will need to be completed by your child's physician and signed by a parent or guardian. The form must be on file in the nurse's office for any student who uses or carries an inhaler. The decision about whether or not your student self-carries or keeps his/her inhaler in the nurse's office is best made by the parent and physician.**

Please contact me if you have any other questions or concerns.

Respectfully,

Jennifer Heaney RN, CSN
Certified School Nurse

482 EAST MAIN STREET ▸ GROVE CITY, PA 16127
PHONE: 724-458-7570 ▸ FAX: 724-458-0444

POSSESSION OF AN "ASTHMA INHALER" DURING SCHOOL HOURS

NEED:

The Grove City Area School District recognizes the need to establish Policy and Procedures on the Possession and Use of Asthma inhalers during school hours.

PURPOSE:

The purpose of this policy is to establish the district's position on the possession, and use of an asthma inhaler during school hours and school activities.

POLICY STATEMENT:

The following procedures shall be used when a student uses an asthma inhaler in school or at school events:

1. The student, parent, or guardian shall provide a written statement from the physician, certified registered nurse practitioner or physician's assistant that states the name of the drug, the dosage, the time(s) when the medication is to be taken, and the diagnosis or reason the medicine is needed.
2. The physician, certified registered nurse practitioner or physician's assistant shall indicate the potential of any serious reaction that may occur to the student, as well as any necessary emergency response.
3. The physician, certified registered nurse practitioner or physician's assistant shall state whether or not the child is qualified and able to self-administer the medication.
4. The written request from the parent or guardian that the school entity comply with the medical practitioner's order shall include a statement relieving the school entity and any school employee of any responsibility for the benefits or consequences of using the prescribed medication when it is parent-authorized. The parent or guardian shall acknowledge that the school entity bears no responsibility for ensuring that the medication is taken.

5. The school entity reserves the right to require a statement from the physician, certified registered nurse practitioner or physician's assistant for the continued use of any medication beyond the specified time period in the medical order. In any event, a new medical order is required annually.
6. Each student that desires to possess and self-administer an asthma inhaler in a school entity setting, will demonstrate to a school district nurse the capability, and associated responsible behavior in the use of an inhaler.
7. Each student will notify the school nurse immediately following each use of an asthma inhaler.
8. No student will share or abuse the use of an asthma inhaler. Misuse will result in confiscation of the inhaler, the medication and the loss of privileges for use in school or at school activities if any parts of this policy are abused or ignored.

Legal Reference:

House Bill No. 1113

Policy Adopted:

3/14/05

*school entity means a district, intermediate center or vocational-technical school.

**Medication Administration Consent And
Licensed Prescriber Order**

Grove City Area School District

Student Name: _____ Date/Time: _____

School: _____ Teacher/Grade: _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy. All medication(s) must be delivered to a license nurse. A student may not transport medication.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the following medication as ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____ Phone: _____

Nurses Signature: _____ Date/Time Rec'd: _____

Amt. Rec'd: _____

FOR PHYSICIAN USE

Licensed Prescriber Medication Order:

Patient's name: _____

Name of medication: _____

Route and dosage: _____

Time of administration: _____

Directions: _____

Discontinuation date: _____

Allergies: _____

Licensed prescriber signature: _____

Licensed prescriber name printed: _____ Phone: _____

Student Asthma Action Plan

The school will use the information provided on this form to develop an individual Asthma Action Plan for your student.

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OF WESTERN PENNSYLVANIA

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201 Smith Drive, Suite E
Cranberry Twp., PA 16066



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of Western Pennsylvania

DATE		SCHOOL	
STUDENT'S NAME		☐ Male ☐ Female	BIRTH DATE GRADE
ADDRESS			
CITY		STATE	ZIP
PARENT / GUARDIAN		HOME PHONE	WORK PHONE
EMERGENCY CONTACT		RELATIONSHIP	PHONE
STUDENT'S PRIMARY DOCTOR		PHONE	DATE OF LAST VISIT
STUDENT'S ASTHMA DOCTOR		PHONE	DATE OF LAST VISIT

ASTHMA SEVERITY

Student's Asthma is: (See Reverse side for definitions)

☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

PAST YEAR ASTHMA HISTORY

Please check all ASTHMA related answers to show what happened in the past year.

School days missed: ☐ None ☐ 1-5 ☐ more than 5
 Emergency Room visits: ☐ None ☐ 1-3 ☐ more than 3
 Hospital admissions: ☐ None ☐ 1-3 ☐ more than 3
 Student uses Peak Flow meter: ☐ Yes ☐ No ☐ Doesn't have one
 Personal best reading: ☐ Yes ☐ No ☐ Doesn't have one
 Student uses a spacer: ☐ Yes ☐ No ☐ Doesn't have one
 Student has inhaler at school: ☐ Yes ☐ No

TRIGGERS

What starts your student's asthma attack? (check all that apply)

☐ Colds ☐ Animals ☐ Food ☐ Smoke ☐ Exercise ☐ Dust ☐ Weather
☐ Other

EARLY WARNING SIGNS

How does your student look, sound, act before an asthma attack? (check all that apply)

☐ Wheezing ☐ Coughing ☐ Chest tightness ☐ Pain in chest ☐ Pain in back
☐ Shortness of breath ☐ Difficulty breathing ☐ Little energy for play
☐ Other

MEDICATIONS

AT HOME	AT SCHOOL	30 MINUTES BEFORE EXERCISE, USE THIS MEDICINE

NOTE: Please notify School Nurse if student required medication before school due to asthma symptoms.

PLEASE REVIEW, SIGN, AND RETURN this form to the School Nurse.

- The information above is correct and should be used when managing my student's asthma at school.
- The School Nurse may share this Asthma Action Plan with all school personnel interacting with my student.
- The School Nurse may contact the family asthma doctor listed above to discuss this information.
- If the student is sent to the emergency department (ED), a follow-up report can be faxed to the School Nurse.
- I give permission to use the "Asthma Tool Kit," a back-up Albuterol inhaler at school (if available).

PARENT / GUARDIAN SIGNATURE

DATE

Student Asthma Action Plan

Helping patients understand Asthma Severity Classification

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The information presented here is to help parents to understand how asthma severity classifications are defined. **NOT ALL CHILDREN FIT PRECISELY INTO THIS CLASSIFICATION.** This information is provided to assist parents in working with their Asthma Doctor in the development of a Student Asthma Action Plan.

Before treatment is started, a child's asthma severity is determined according to various criteria. These criteria often overlap. The most severe step in which any criteria occur is used to classify the child's asthma. Your Doctor may assign a severity classification while your child is taking medication but still hasn't achieved best control.

SYMPTOMS	CLASSIFICATION
Does your child: Cough, wheeze, or has shortness of breath- LESS THAN two times a week Short duration of symptoms (generally a few hours to a few days) Nighttime asthma symptoms no more than two times per month Between episodes, is symptom free Peak Flow GREATER THAN 80% of personal best (green zone)	MILD INTERMITTENT
OR has: Persistent symptoms Episodes MORE THAN two times per week Nighttime asthma symptoms MORE THAN two times per month Peak Flow GREATER THAN 80% of personal best (green zone) Cough variant asthma	MILD PERSISTENT
OR has: Daily symptoms Episodes affecting activity and sleep Nighttime asthma symptoms MORE THAN one time per week Daily use of short-acting inhaler Peak Flow GREATER THAN 60% but LESS THAN OR EQUAL TO 80% of personal best (yellow zone)	MODERATE PERSISTENT
OR has: Continuous symptoms Frequent episodes Frequent nighttime asthma symptoms Physical activities limited by asthma symptoms Severe episodes in spite of medication Peak Flow LESS THAN 60% personal best (red zone)	SEVERE PERSISTENT

After your child's asthma is under control, your Doctor may classify your child's asthma according to the treatment needed to maintain control. For example:

Mild intermittent – no daily medication is needed.

If your child starts using a rescue medication more than 2 times per week, your Doctor may suggest the need to start long-term control medication.

Mild persistent – one daily long-term control medication is necessary.

Moderate persistent – inhaled corticosteroids with or without additional long-term control medications as indicated.

Severe persistent – multiple long-term control medications are required, including high-dose inhaled corticosteroids and, if needed, oral corticosteroids.