THORNWOOD HIGH SCHOOL

17101 South Park Avenue · South Holland, Illinois 60473

Mr. Dennis Willis
Principal

Dear Parent/Guardian:

As part of our school's asthma management program, your child will work with the school nurse and other staff to follow his or her asthma action plan and learn how to reduce asthma symptoms and asthma attacks.

In order to provide the best possible asthma management for your child at school, we ask for your help with the following. Please:

- Get a written asthma action plan from your child's doctor or other health care provider and give a copy to your child's classroom teacher or the school health office. This asthma action plan states your child's treatment goals, medications and peak flow plan, and steps to reduce your child's asthma triggers. Please be sure the asthma action plan includes instructions for managing symptoms during special activities at school or away from school. Activities and events can include recess, gym, outdoor play, field trips, parties, and art and music class. You may use the enclosed form or a form from your child's health care provider. If your child does not have a primary care provider, please talk with our school health team to work out a plan to support your child's asthma needs.
- Fill out the enclosed medication administration form(s) for any medication to be given at school or during school-sponsored activities away from school and submit it to your child's teacher or the school health office. Provide the health care provider's signature and the enclosed form if your child is to carry and take his or her own medication at school and school-sponsored activities. Please bring in medications in original containers with pharmacy labels; do not send medication in with your child. Keep medications refilled as needed, and check for expiration dates that may occur during the school year. If your child carries his or her own medication, and you would like to leave a second inhaler to store at school, you are welcome to do so.
- Meet with the school nurse—before school starts and as needed through the school year—to discuss your child's condition, medications, devices, and asthma triggers.
- Meet with teachers and other staff to develop a plan for communication and handling any work or tests your child might miss during school absences due to asthma. Also meet with physical education teachers and coaches to discuss any special needs related to exercised-induced asthma.

Ms. Kelly Hock
Assistant Principal
(708) 225-4704

Mr. Don Holmes
Assistant Principal
(708) 225-4702

Mr. Tom Walsh
Assistant Principal
(708) 225-4703

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- Prepare your child. Be sure your child understands his or her medication plan and how to handle symptoms, triggers, and food restrictions. Discuss school policies that relate to your child's asthma management (such as rules about medication use).
- Tell school staff about any changes in your child's condition or asthma action plan.
- Tell your child's doctor or other health care provider about school services and supports for helping your child manage his or her asthma.
- Please note that medication orders, such as inhalers and nebulizer treatments, must be renewed at the beginning of each school year.

Our asthma management program also includes the following components, which will help support your child's asthma control while at school:

- Asthma training for all school staff so they are prepared to follow students' asthma action plans, to identify asthma symptoms and warning signs of asthma attacks, and to handle emergencies related to asthma
- A supportive environment that encourages respect for others

Thank you for working with us to help your child. If you have questions or concerns about keeping your child's asthma well controlled while at school, please contact the school nurse's office.

Sincerely,

THORNWOOD HIGH SCHOOL

SCHOOL NURSE'S OFFICE

708-225-4778/4779/4090

Fax: 708-225-4856

Ms. Kelly Hock
Assistant Principal
(708) 225-4704

Mr. Don Holmes
Assistant Principal
(708) 225-4702

Mr. Tom Walsh
Assistant Principal
(708) 225-4703

THORNTON TOWNSHIP HIGH SCHOOLS DISTRICT 205
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT NAME_____ BIRTHDATE _____

ADDRESS_____ PHONE NUMBER_____

SCHOOL_____ GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I,_____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Thornton Township High Schools District 205 (the "District"), and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of the District, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the District, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

II. TO BE COMPLETED BY THE STUDENT'S LISCENSED PRESCRIBER
(Except for a Student Self-Administering Asthma Medication, see Section III below)

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Epinephrine: _____Yes _____No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of Epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of doing this independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____Yes _____No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____

Phone Number of Physician | Signature of Physician | Date

_____ _____

Address of Physician | Print Name of Physician | Date

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
Before exercise	☐ _____	☐ 2 or ☐ 4 puffs _____	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

Add

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

_____ ☐ 2 or ☐ 4 puffs, every 20 minutes for up to 1 hour
(short-acting $beta_2$-agonist) ☐ Nebulizer, once

Stop

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
☐ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
☐ Take: _____ ☐ 2 or ☐ 4 puffs or ☐ Nebulizer
(short-acting $beta_2$-agonist)
☐ Add: _____ mg per day For _____(3–10) days
(oral steroid)
☐ Call the doctor ☐ before/ ☐ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

☐ _____ ☐ 4 or ☐ 6 puffs or ☐ Nebulizer
(short-acting $beta_2$-agonist)

☐ _____ mg
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ☐ 4 or ☐ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ NOW!**
(phone)

See the reverse side for things you can do to avoid your asthma triggers.

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

❒ Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

❒ Dust Mites

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

❒ Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

❒ Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

❒ Pollen and Outdoor Mold

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

❒ Tobacco Smoke

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

❒ Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

❒ Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

❒ Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

U.S. Department of Health and Human Services
National Institutes of Health

National Heart
Lung and Blood Institute

For More Information, go to: www.nhlbi.nih.gov

NIH Publication No. 07-5251
April 2007