



ASTHMA / RAD
Emergency Care Plan / 504

Student Name:	DOB:	Grade:
School:	School Year:	
Advisor:	Transportation: <input type="checkbox"/> Walker <input type="checkbox"/> Car <input type="checkbox"/> Bus Rider	
Inhaler Stored: <input type="checkbox"/> With Student <input type="checkbox"/> Health Room <input type="checkbox"/> Class <input type="checkbox"/> Coach <input type="checkbox"/> Other:		
Life-threatening Allergies? <input type="checkbox"/> YES (High risk for Severe Reaction) Allergies to: <input type="checkbox"/> No		

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

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

For symptoms of cough, wheeze, SOB:

1) Give _____ 2 puffs 4 puffs by mouth, every 2h 4h 6 hrs as needed

2) If symptoms not resolved, give _____ by inhaler, 2 puffs 4 puffs by mouth _____ minutes after step 1

Prior to PE or exercise:

1) Give _____ 2 puffs 4 puffs by mouth _____ minutes prior to exercise
 as needed scheduled

Side Effects: Increased heart rate, shakiness, other: _____

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

Yes No Can this student **responsibly carry** the emergency medication in their backpack/purse?

Yes No Can this student **responsibly self-administer** the emergency medication?

Yes No Student demonstrated for the LHCP the skill necessary to self-administer the medication?

HCP Signature: _____ **Date:** _____

HCP Printed Name: _____ **Phone:** _____ **Fax:** _____

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

Moderate Symptoms	Immediate Response
<ul style="list-style-type: none"> Excessive Coughing Wheezing Shortness of Breath Chest tightness Nostrils flaring Shoulders hunched over Anxious or scared 	<ul style="list-style-type: none"> Accompany student to health room (Do Not Send Alone) Give medication as prescribed by LHCP 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
<ul style="list-style-type: none"> Lips or nail beds turning pale or blue Grunting Inability to speak in complete sentences without taking a breath Severe restlessness Decreasing or loss of consciousness 	<ul style="list-style-type: none"> CALL 911 Notify Parent Notify School Nurse Notify School Principal Do not leave the student unattended.

MEDICAL INFORMATION

This section to be completed by parents/guardian

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

EMERGENCY CONTACTS

Parent/Guardian	Phone	Relationship
1.		
2.		
Emergency Contact	Phone	Relationship
1.		

PARENT/GUARDIAN CONSENT – You must complete and SIGN

- I consent to the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student Rights.
- 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.
 - 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 health room.
- I am a student and 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 healthcare provider.

The transportation department and appropriate school staff will be alerted to the student’s health condition.

Parent Signature: _____	Date: _____	<input type="checkbox"/> Parent/Guardian Signature on File
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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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School Nurse Signature: _____	Date: _____
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