717 JORDAN PUBLIC SCHOOLS
500 Sunset Drive
Jordan, Minnesota 55352
952-492-6200 main | 952-492-4445 fax

DISTRICT NURSE
jordannurse@isd717.org

ASTHMA EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has Asthma or Reactive Airway Disease.

Please complete the **Asthma History Form**. This will help us better understand your child's asthma. Please have your child's physician complete and sign the "School Asthma Plan and Medication Orders" form.

All medication brought to school must be in its **original package, unexpired, and must contain the original label from the pharmacy**. Any medication received that is expired or without labeling from your child's pharmacy will be sent back home.

If your child needs to carry an inhaler with him/her, your child's physician must indicate this on the order page. If your child will carry the inhaler with him/her, it is recommended that an extra inhaler is stored in the nurse's office should he/she forget their inhaler at home.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

Thank you and please call or email us if you have any questions or concerns.

Darci Griffiths MSN, RN, LSN
District Nurse - JHS
952-492-4410
jordannurse@isd717.org
Fax: 952-492-4425

Jenn Passe, RMA
Jordan Middle School
952-492-4232
Fax: 952-492-4450

Jenna Hentges, RN
Jordan Elementary School
952-492-4278
Fax: 952-492-4446

Asthma History - Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____ Date:_____

Parent/Guardian Name: _____

Home Phone:_____ Work Phone: _____

Alternate Contact: _____Phone: _____

Primary Health Care Provider: _____ Phone: _____

When was this student's asthma first diagnosed?_____

How many times has this student been seen in the ER for asthma in the past year? _____

How many times has this student been hospitalized for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? _____

When? _____

How would you rate the severity of this student's asthma?

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days did this student miss last year because of asthma? _____

What triggers this student's asthma?

❏ exercise ❏ respiratory infection ❏ strong odors or fumes ❏ stress
❏ cigarette smoke ❏ wood smoke ❏ pollen

❏ animals (specify): _____

❏ foods (specify): _____

❏ carpets ❏ indoor dust ❏ outdoor dust

❏ chalk dust ❏ temperature changes ❏ molds

❏ other: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

❏ breathing exercises ❏ rest/relaxation ❏ drinks liquids

❏ takes medications (see below) ❏ uses herbal remedies (see below)

❏ other (please describe):

_____

Student's Name _____

What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	How Often

What herbal remedies, if any, does this student take for asthma?

_____

Does this student use any of the following aids for managing asthma?

❑ peak flow meter (personal best if known)_____ ❑ holding chamber

❑ spacer ❑ holding chamber w/mask

❑ other: _____

Please check special needs related to your child's asthma:

❑ physical education class ❑ recess ❑ animals in classroom

❑ avoidance of certain foods ❑ field trips ❑ access to water

❑ transportation to and from school ❑ other _____

❑ observation of side effects from medications

If you checked any of the above boxes, please describe needs: _____

_____

_____

Has this student had asthma education? ❑ yes ❑ no

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Asthma Action Plan and Medication Orders

Name _____ DOB ____ /_____ /_____

Peak Flow Meter Personal Best _____ **School does not provide peak flow meters**

Green Zone: Doing Well

Symptoms: Breathing is good - No cough/wheeze - Can work/Play - Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	How often to take
	_____	_____	_____
	_____	_____	_____

Physical activity ❑ Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity

❑ with all activity ❑ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing - Cough, wheeze or tight chest - Problems working/playing - Wake at night

Peak Flow Meter _____ -_____ (50-79% of personal best)

Quick-relief Medicine(s) ❑ Albuterol/Levalbuterol _____ puffs, every 4 hours as needed

Control Medicine(s) ❑ Continue Green Zone medicines

❑ Add_____ ❑ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the yellow zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor ASAP!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing - Cannot work or play - Getting worse instead of better - Medicine not working

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ❑ Albuterol/Levalbuterol _____ puffs, _____ (frequency)

Call 911 immediately if the following danger signs are present - Trouble walking/talking due to breathing

- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Check all that apply:

❑ **Student understands the proper use of his/her asthma medications and may carry and use his/her inhaler at school independently**

❑ Student needs supervision or assistance to use his/her inhaler.

❑ Student has life threatening allergy, refer to anaphylaxis plan.

Physician Signature_____**Date**_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____