

Asthma Action Plan (AAP)

School Health Plan (SHP)

Emergency Action Plan (EAP)

Medication Authorization & Self-Administration FormIn accordance with UCA 53G-9-503 Utah Department
of Health/Utah State Office of Education**PHOTO**Nursing & Health Services
Phone 435-752-3925
Fax 435-792-7796**RN Approval****Date:**Does student have a history of **SEVERE ALLERGY (ANAPHYLAXIS)** where epinephrine was used? ☐ Yes ☐ No
IF YES, please also complete Allergy Action Form Allergy to: _____**STUDENT INFORMATION**

Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Email:		
School Nurse:	Phone:	Email:		

SEVERITY CLASSIFICATION☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent**TRIGGERS**☐ Illness ☐ Exercise ☐ Animals ☐ Smoke ☐ Dust ☐ Food ☐ Weather ☐ Air Quality ☐ Pollen ☐ Other:**AIR QUALITY**

Student should stay indoors when Air Quality Index is:

☐ Moderate	☐ Unhealthy for Sensitive groups	☐ Unhealthy	☐ Other:
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EXERCISETake quick-relief medication (see medication order
in Yellow section below):☐ Before exercise/exposure to a trigger
☐ Other (specify):**GREEN: DOING GREAT!****ACTION**Student has **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Able to work and play normally

Controller medication (taken at home)

How much?

How often?

Yellow: Mild to Moderate Distress**ACTION**Student has **ANY** of these:

- Coughing or wheezing
- Tight Chest
- Shortness of breath
- Waking up at night

Quick-relief medication

How much?

How often?

Administer Via ☐ Inhaler ☐ Nebulizer
☐ Inhaler with spacer☐ Student is independent
☐ Student needs assistance
☐ Student needs supervision

1. Restrict physical activity and allow to rest upright.
2. Do not leave student unattended. Observe continuously for 15 minutes.
3. Notify parent/guardian.
4. If improved (breathing smooth and easy, no coughing or wheezing) may return to class.
5. If no improvement **CALL 911** and move to **RED** section below.

Red: Severe Respiratory Distress**ACTION**Student has **ANY** of these:Trouble eating, walking or talking
Breathing hard and fast
Medicine isn't helping
Rib or neck muscles show when
breathing in
Color changes in lips, nail beds, skinRepeat ____ puffs of quick-relief medication (each 15-30 seconds apart) every ____
minutes until medical help arrives.
Encourage slow breaths and allow individual to rest.
Update parent/guardian.
Do not leave student unattended. Observe continuously until EMS arrives.
☐ Additional Orders (specify):

PRESCRIBER TO COMPLETE

The above-named student is under my care and has the diagnosis of Asthma. In order to keep this child in optimum health and to help maintain school performance, it is necessary that these orders are to be completed during school hours. This order expires at the end of the current school year or on an earlier date set by the provider: _____.

☐ It is medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.

☐ It is **not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT OR LEGAL GUARDIAN TO COMPLETE

RESPONSIBILITIES (Parent/Guardian must sign in both places)

- Bring student's asthma medication to the school. The medication must be in the original pharmacy container with a pharmacy label that has the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- Replace the asthma medication when empty.
- Provide any new prescribing or dose information to the school if there is a change in the student's prescription.
- Complete an updated Asthma Action Plan before the designated staff can administer the updated prescription.

**PARENT/GUARDIAN AUTHORIZATION (Must sign in both places)
Checked boxes must match with Health Care Provider Order above**

☐ I **authorize** my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.

☐ I **authorize** the appropriate/designated school personnel to maintain my child's medication for my student to self-administer in an emergency.

☐ I **do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

Parent Signature:	Date:
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I authorize my child to receive specified procedures at school as directed by the healthcare provider and/or agreed upon with the District RN. As the parent/guardian of the above-named student, I authorize District RN(s) and trained, designated unlicensed staff to perform tasks outlined in the Health Plan/Emergency Action Plan. I release, indemnify, and hold harmless the District RN(s) and designated staff from any claims related to health interventions, provided they follow the healthcare provider's written instructions and/or agreed upon within this plan of care. I consent to communication and information sharing between the prescribing provider and District RN(s) as needed for managing my student's condition and administering medication. I understand that the information in this plan will be shared with school staff and EMS as necessary. EMS will be called in emergencies. I will notify District RN(s) of any changes in my child's health status, care, or medication. Parents/guardians and the student are responsible for providing all required supplies, medications, and equipment. **This order expires at the end of the current school year or on an earlier date set by the provider: _____.** I understand that this document is not valid, and no accommodations will be made, until it is signed by all required parties.

Parent Signature:	Date:
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Emergency Contact Name:	Relationship:	Phone:
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SCHOOL NURSE (or school office staff, health aide)

☐ Signed by physician and parent ☐ Medication is appropriately labeled ☐ Medication log generated

Inhaler is kept: ☐ Front Office ☐ Student Carries ☐ Backpack ☐ Other (specify):

This health care plan is to be distributed via PowerSchool or as needed by **front office** to all "need to know" staff.

School Nurse Signature:	Date:
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