

For _____ School Year (expires
at the end of August)

**SHORELINE SCHOOL DISTRICT
PROVIDER TREATMENT PLAN AND MEDICATION ORDER FOR ASTHMA**

Note: These orders *must* be renewed every year, before the beginning of each school year

**Briarcrest Elementary
2715 NE 158th St
Shoreline, WA 98155**

**ATTENTION: Susan Vieira, RN
PHONE 206-393-4176
FAX 206-393-4174
EMAIL susan.vieira@ssd412.org**

Student Name: _____ Birth date _____ Grade/Grad Yr. _____
Licensed Healthcare Provider* _____ Phone _____ Fax _____

SCHOOL MEDICATION ORDERS – TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER*

Health condition requiring administration of medication (**Please circle**): Asthma Other _____
Medication: _____ Dosage: _____ Route: _____ Time: _____
Medication: _____ Dosage: _____ Route: _____ Time: _____
Possible side effects: _____

PLEASE COMPLETE ASTHMA TREATMENT PLAN BELOW – required for self-carry/self-administration

*An alternative Asthma Treatment Plan can be substituted, but school medication orders **MUST** be included*

GREEN ZONE: No coughing, no wheezing, breathing is unlabored

Controller medications to be used at home: _____

☐ **STUDENT NEEDS EXERCISE PRE-TREATMENT PRIOR TO STRENUOUS PHYSICAL ACTIVITY:**

1. Give _____ PUFFS quick-relief inhaler listed above _____ minutes prior to strenuous physical activity
2. Other instructions: _____

YELLOW ZONE: Mild/moderate symptoms (cough, wheeze, chest tightness, difficulty breathing)

1. Give _____ PUFFS quick-relief inhaler listed above
2. Restrict strenuous physical activity until symptoms improve
3. If symptoms do not improve or are getting worse, repeat dose after _____ minutes
4. If symptoms do not improve after repeated dose or are getting worse (medication is not working) **GO TO RED ZONE** instructions

RED ZONE: Severe symptoms (*very short of breath, continuous coughing, ribs visible during breathing, trouble walking or talking, lips or nails turning pale or blue, not responding to medication*)

CALL 911 AND PARENT/GUARDIAN. DO NOT LEAVE STUDENT UNATTENDED

1. Give _____ PUFFS quick-relief inhaler listed above
2. If symptoms do not improve or are getting worse, repeat dose after _____ minutes
3. **Give no more than a total of _____ PUFFS of quick relief inhaler in one hour**

Other instructions for this student: _____

Student may carry quick-relief inhaler in backpack: ☐ YES ☐ NO

Student may self-administer quick-relief inhaler: ☐ YES ☐ NO

Student has demonstrated use to Licensed Healthcare Provider* ☐ YES ☐ NO

Per RCW 28.A.210.370 "Students with Asthma", students must have a written treatment plan and must demonstrate the proper use of medication prior to being granted the ability to self-administer medication at school.

Parent/Guardian AND Licensed Healthcare Provider **MUST COMPLETE PAGE 2 →**

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

I request and authorize that the above-named student be administered the above-identified medication as per the instructions/treatment plan indicated above from the [dates] _____ to _____ [not to exceed the current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

Licensed Healthcare Provider* Signature

Date

Phone

TO BE COMPLETED BY PARENT/GUARDIAN

PARENT/GUARDIAN REQUEST: I request that the school nurse, or designated staff member, administer the medication(s) described above as directed by the above Licensed Healthcare Provider. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.

I give my consent for the confidential information contained on this form to be faxed to the above-named school.

Parent/Guardian Signature

Date

Parent/Guardian Name (print)

Address

Phone

SCHOOL NURSE USE ONLY

Inhaler to be stored:

☐ With student (backpack)

☐ Health Office

☐ Other: