SUMNER COUNTY SCHOOLS
IHP/SAFETY PLAN: ASTHMA DISORDER

Student Name_____ DOB _____

School_____ Grade_____ School Year_____

ASTHMA RISK: ☐ Mild ☐ Moderate ☐ Severe

Triggers (list) _____

Control Medications Taken at Home_____

Protocol for student having an asthma attack:

1. Encourage student to remain calm, take slow, deep breaths, and sit upright.
2. Administer emergency asthma medications as prescribed (if available).
3. Stay with student and monitor response.
    - If symptoms improve with treatment, student may return to normal activity.
    - If symptoms persist or worsen, contact SET/School Nurse, call parent/guardian, and proceed to **Emergency Action Plan**.

Call 911 immediately if:

- Trouble walking/talking due to shortness of breath
- Bluish tint to lips/fingernails
- Increased work of breathing requires visible strain of chest, neck, or shoulder muscles
- Decreased level of consciousness

Emergency Action Plan

1. Activate EMS/Call 911 if assessment warrants.
2. Stay with student and continue to monitor breathing and general condition.

PHYSICIAN'S ORDER: EMERGENCY MEDICATIONS TO BE ADMINISTERED AT SCHOOL DURING ASTHMA EPISODE

Medication	Dosage/Route	Administration Time/Frequency	Purpose	Start/Stop Date

For Inhaled Medications (Please check ONE of the following):

☐ I have instructed this student in the proper way to use his/her inhaled medication. It is my professional opinion that he/she should be **ALLOWED TO CARRY** and use their prescribed inhaler.

☐ It is my professional opinion that this student **SHOULD NOT** carry his/her inhaled medications but should receive assistance with administration from an adult.

Physician's Signature_____ **Date**_____

Physician's Name (Print) _____ **Phone**_____

PARENT/GUARDIAN AUTHORIZATION (Required)

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parents indicate agreement with the plan of action as described by health care provider.

Parent/Guardian's Signature _____ Date _____

Parent's Name (Print) _____ Phone _____

School Nurse Signature _____ Date _____