Fife School District Special Services

LIFE THREATENING ASTHMA EMERGENCY MEDICAL & IHP

Photo

Name:		Asthma Triggers: Last Severe Episode:	
School:	Grade:	Birth Date:	Asthma level: (circle) intermittent mild moderate severe

Confidential Information _____ School Year

MEDICATION ORDERS

TREATMENT PLAN for managing asthma at school is as follows (Check all that apply):

☐ **Administer rescue medication** if student experiences symptoms (coughing, difficulty breathing, wheezing, chest tightness)

☐ **Side Effects of Drug:** If any are to be expected: Rapid Pulse, Jitteriness,_____

Drug and Dosage Form	Dose, Time and Mode of Administration
☐ Albuterol Inhaler ☐ Xopenex / Levabuterol ☐ w/ Spacer	☐ 2 (or____) puffs by mouth 5-20 minutes prior to exercise. ☐ 2 (or____) puffs by mouth every 3-4 hours PRN for symptoms ☐ If NO relief after treatment: call 911 ☐ Other:
☐ Albuterol via Nebulizer ☐ Levabuterol via Nebulizer ☐ Mouthpiece ☐ Mask	☐ 1 unit dose every_____ hours as needed for symptoms ☐ Other:
☐ Other:	

☐ Use peak flow meter
☐ Student to inform school nurse if **using albuterol inhaler more than 4 times/day** or if asthma causes awakening at night
☐ Student has been **instructed in use of device** needed to administer medication
☐ Student has **demonstrated the skill level** necessary to use the medication appropriately
☐ Student **recognizes symptoms of asthma and will seek assistance** if needed
☐ Student may **carry and self-administer the medication** ordered above

Licensed Health Care Provider's Signature: (and IHP team member)	Date:	
LHCP's Printed Name:	Phone:	Fax Number:

- I request the medication specified above be **given as ordered by the licensed health care provider**.
- All medication supplied must come in the **original provided container** with above instructions noted by the licensed health care provider.
- I understand the above medication(s) **may not always be given by a school nurse**. Trained and supervised designated staff are available when the nurse is not.
- I give Health Services Staff permission **to communicate with the medical office** about this medication.
- Medical/Medication **information may be shared with school staff** working with my child and 911 staff, if they are called.

Parent/Guardian Signature: _____ Date: _____

ACTION PLAN

- **DO NOT HESITATE:** Immediately administer: **medication indicated above**
  - **NOTE TIME it was given** _____
- **CALL 911 and parent/guardian.** Advise 911: medication was administered to a student and when.
- Adult to stay with student, monitor and begin CPR if necessary, stay until EMS arrives.
- Call the School Nurse at: _____ and notify building administrator.
- Give a copy of this Emergency Medical Plan to the EMS.

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School guidelines for determining IHP. Does student's asthma substantially impair a major life activity? Check all that apply

Overnight hospitalization for asthma in past 2 years **Emergency room visit** in past year for uncontrolled asthma Student **CANNOT reliably report having an asthma episode**	Diagnosed: **Severe persistent asthma** by LHCP Student has **unstable asthma** control Other:

_____ **NO** Student's asthma **does not substantially impair** a major life activity: therefore does not qualify for an IHP.

IF **NO Stop here:** Document parent responses in Health Record. School Nurse: _____ Date: _____

Individual Health ACCOMMODATION PLAN for School

Bus route : Car ☐ Walk ☐	Previous Severe Symptoms: Ever Hospitalized for Asthma: When:
Medications at school: ☐ Inhaler ☐ Nebulizer	**Medication is stored** : ☐Health Room ☐Other:
Other Medications :	

Individual Health ACCOMMODATION PLAN for School

PE, Recess and Special Events :
Prior to or During these events:
Other:

Transportation: Student carries an inhaler on the bus?

Field Trip: Teacher will carry medication. If 911 is called: Stay with student, notify parents and school nurse. Give IHP to EMS.
Should student remain with teacher or family member during entire field trip?

Other accommodations as deemed appropriate:

Teachers: Please place a copy of this plan in your **substitute folder** .

ACTION PLAN: **Never send a student ALONE if they are experiencing breathing difficulties**

IF YOU SEE ANY of These	DO THIS
• Coughing or wheezing • Have tightness in chest • Shortness of breath • Verbalizes needing inhaler •	• Accompany student to health room • Give medications (inhaler or nebulizer) as prescribed • Keep student sitting up and reassure student • Encourage student to drink water •
• Very short of breath • Hard time walking or talking • Lips or fingernails are grey or blue • Skin around neck or between ribs pulling in • Medication did NOT help after 15 minutes	• Call 911 • Notify Parent • Call School Nurse/Office • Stay with student and keep student sitting upright • Give medical plan to EMS responders

- Team members agree this student's severe asthma **substantially impairs** a major life activity and is **eligible** for Section 504.
- **Various sources of information were considered**: Medical information from LHCP, Parent, Nurse and academic setting.

Parent/Guardian, Health Team Member:_____ Date:_____

School Nurse, Health Team Member: _____ Date:_____

The information from this plan will be shared with: Parent, Teacher(s), Principal, Office Staff, Transportation, and Food Service. Other: (Elementary: Specialists and Recess Personnel) (Coaches when applicable).

If sent electronically to school staff, signed original is kept: in Health Room.