ASTHMA HEALTH PLAN AND MEDICATION ORDERS

Click to place student picture here

Student Name:	Birthdate:	Plan # : of
School:	School Year:	Grade:
☐Bus# ☐Walk ☐Drive ☐ Sport/Activity/PE:	Height:	Weight:

History of Anaphylaxis ☐ Yes ☐ No

History (including current medication): _____

_____

_____

Asthma Triggers (check all that apply): ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens ☐ Smoke, chemicals, strong odors ☐ Respiratory illness/virus ☐ Other _____ (i.e., foods, emotions, insects, etc.)

Usual Asthma Symptoms (check all that apply): ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest Tightness ☐ Asking to use inhaler ☐ Other _____

Inhaler(s) location: ☐ Office ☐ Backpack ☐ On person ☐ Other_____

Epinephrine location: ☐ Office ☐ Backpack ☐ On person ☐ Other_____

This Section to be Completed by a Licensed Healthcare Provider (LHP)

GO ZONE (GREEN) INFREQUENT/MINIMAL SYMPTOMS

Symptoms and/or use of quick relief medication < 2 times per week, does not include exercise pre-treatment usage. Infrequent and minimal symptoms like cough, wheeze, and shortness of breath. Full participation in physical education and sports is allowed.

If student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff:
➔ **Notify school nurse-phone # _____ and parent/guardian.**

GREEN ZONE
Peak Flow Range
_____ to _____
☐ N/A Peak Flow

CAUTION ZONE (YELLOW) *SIGNIFICANT SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED*

SYMPTOMS INCREASE: Cough, wheeze, chest tightness, or shortness of breath, can do some, but not all, usual activities.

ADMINISTER: ☐ **Quick-relief Medication: _____ Number of puffs: _____**
☐ **Use spacer/chamber with inhaler**
☐ **Quick-relief Medication via Nebulizer**: _____ **Dosage: _____**

Can repeat every _____ minutes up to maximum of _____ doses

- If symptoms (and peak flow, if used) resolve student returns to GREEN ZONE guidance
- If symptoms (and peak flow, if used) **do not** return to GREEN ZONE after 1 hour of above treatment:
  Administer ☐ Quick-relief Medication: _____ Number of puffs: _____
  OR ☐ Nebulizer (2nd dose)
- Contact school nurse (if available) and parent/guardian. Student should not remain at school at this point.
- Continue to stay with and monitor the student until parent/guardian arrives.

YELLOW ZONE
Peak Flow Range
_____ to _____

EMERGENCY ZONE (RED) *EXTREME SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED*

If student is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working.

➢ **CALL 911** ☐Give 4 puffs quick relief inhaler (or nebulizer treatment)
☐Administer epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)
☐Neffy ☐ 2 mg ☐ 1 mg
☐Other _____
➢ Contact school nurse (if available) and parent/guardian. Adult stays with student.

RED ZONE
Peak Flow Range
Below: _____

EXERCISE PRE-TREATMENT: ☐ N/A PE/Sports: Day/Time/Periods _____
☐Give 2 puffs of quick relief inhaler 15- 30 minutes prior to PE or other strenuous exercise
If asthma symptoms occur during exercise, follow CAUTION ZONE (YELLOW) instructions. Notify nurse and parent/guardian.

Daily Controller Medication_____ Dose_____ Time_____
☐ Takes daily controller medication at home ☐ Administer daily controller medication at school
SIDE EFFECTS of medication(s): increased heart rate, shakiness

This student demonstrated correct use of the rescue inhaler and epinephrine in the LHP's office as required ☐ Yes ☐ No
☐ Student can carry and self-administer rescue inhaler and epinephrine ☐ Needs help administering rescue inhaler and epinephrine

LHP Signature:	LHP Print Name:	
Start date:	End date ☐ Last day of school ☐ Other	
Date:	Telephone:	Fax:
Preferred Hospital:		

ASTHMA HEALTH PLAN – PART 2 – PARENT/GUARDIAN

Student Name: _____

Transportation staff should be alerted to student's asthma

- Student carries inhaler/epinephrine on the bus/transportation: ☐Yes ☐No
- Inhaler(s) location: ☐Backpack ☐On person ☐Health Room ☐Other:_____
- Epinephrine location: ☐Backpack ☐On person ☐Health Room ☐Other:_____
- Student will sit at front of the bus: ☐Yes ☐No

Field Trip/Extracurricular Activity: Inhaler and Health Plan must accompany student during any off-campus activity

- The student must remain with the teacher or parent/guardian during the entire field trip: ☐Yes ☐No
- Field trip staff must be trained to medication and Health Plan
- Other Accommodations: _____

EMERGENCY CONTACTS:

Parent/ Guardian	Name	Parent/ Guardian	Name
	Primary #		Primary #
	Other #		Other #

Name:	Relationship:	Phone:

My child may carry and is trained to administer their rescue inhaler	☐Yes	☐ No	Provide extra for office	☐Yes ☐No
My child may carry and is trained to self-administer their epinephrine	☐Yes	☐ No	Provide extra for office	☐Yes ☐No
My child needs to carry their rescue inhaler and/or epinephrine- and will need assistance with administration				☐Yes ☐No

- A new Health Plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the Health Plan, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- I understand that the school district cannot be held responsible for negative outcomes resulting from my child self-administering their medication at my request.
- Medical information may be shared with school staff working with my child, and EMS staff, if they are called.
- This is a life-threatening Health Plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's asthma between the LHP office and the school nurse.

My child needs classroom, school activity, or recess accommodations ☐ Yes ☐ No

➢ If yes, please contact the school counselor, school nurse, or 504 coordinator.

For 504 Plans:

- I consent to the evaluation and annual re-evaluation of my child under 504 laws regarding their Health/504 Plan.
- If additional accommodations are needed, I will contact the school nurse to communicate the needed change to the Health/504 Plan.
- I understand that these accommodations will be reviewed by my child's educational team and provided to staff as needed.
- My signature below shows I have reviewed and agreed with this Health/504 Plan and medication/treatment orders.

Parent/Guardian Signature: _____ Date:_____

Student (for all students but required for student who self-carries/self-administers rescue inhaler and/or epinephrine):

- I have demonstrated the correct use of the rescue inhaler and/or epinephrine to the medical provider and the school registered nurse.
- I agree never to share my inhaler and/or epinephrine with another person or use it in an unsafe manner.
- I agree that if there is no improvement after using inhaler and/or epinephrine I will report to an adult.

Student Signature:_____ Date:_____

The Health Plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management.

Some students are capable of carrying and using their quick relief inhaler by themselves. The student, the student's parents, school nurse, and the healthcare provider will collectively make this decision. The school nurse must also evaluate the technique for effective use.

For school District Nurse Only ☐ **504 Plan**

A registered nurse has completed a nursing assessment and developed this Asthma Health Plan in conjunction with the student, their parent/guardian, and their LHP.

Student may carry and self-administer the medication(s) ordered above: ☐Yes ☐No

If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: ☐Yes ☐No

Device(s) if any, used:_____ Expiration date(s):_____

Registered Nurse Signature:_____ Date:_____ Phone:_____

A copy of the Health Plan will be available to all staff members who are involved with the student, including substitutes.