ASTHMA IHP/ECP/504 PLAN & MEDICATION ORDERS

Place student picture here

NAME:			**Birthdate:**	
Grade:	**School:**	☐ **Bus #**	☐ **Walk**	☐ **Drive**
☐ **History of anaphylaxis**	**Physical Activities (sports)**			
Brief medical history:				
Date of last hospitalization:	**Weight:**			

Inhaler(s) location: ☐ OFFICE ☐ BACKPACK ☐ OTHER:

Epinephrine auto-injector (**EAI**) location: ☐ OFFICE ☐ BACKPACK ☐ OTHER:

Asthma Triggers: ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens ☐ Exercise

☐ Smoke, chemicals, strong odors ☐ 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______________________

SECTION BELOW TO BE COMPLETED BY STUDENT'S LICENSED HEALTHCARE PROVIDER (LHP)

ASTHMA TREATMENT INSTRUCTIONS: (check all that apply)

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 short of breath
- Full participation in physical education and sports

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

- If Student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff ➔**Notify parents and nurse**
- If Student is coughing, wheezing, and having difficulty breathing:
  - ☐ Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. ➔**Notify parents and nurse if repeated**
  - ☐ Other: ____
- Until symptoms are in the GO ZONE (green), restrict strenuous physical activity.
- **If no improvement after repeated dose Call 911—See below**

STOP ZONE (RED) CALL 911 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) and notify parents and school nurse.

☐ This student needs Epinephrine for severe asthma attacks and

☐ Needs help giving the Epinephrine ☐ Other:____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ N/A

☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to PE or other strenuous exercise.

☐ May repeat 2 puffs of quick relief inhaler if symptoms occur. Follow "YELLOW" intructions➔**Notify parents and nurse if occurs.**

Quick relief medication orders: (check the appropriate quick relief med(s) ☐ Uses inhaler with spacer

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) as needed every 4 hours for cough/wheeze

☐ Levalbuterol 2 puffs (Xopenex®) as needed every 4 hours for cough/wheeze

☐ Other ___________________________ Epinephrine auto-injector ☐ 0.3 mg ☐ Jr. 0.15 mg

☐ **Daily Controller meds:** ____ dose ________________time ____________

☐ Takes daily controller medications at home ☐ Takes daily controller medications at school

SIDE EFFECTS of medication(s): increased heart rate, shakiness,

This student demonstrated correct use of the inhaler in the LHP's office as required. ☐ Yes ☐ No

This student is able to carry and use inhalers ☐ Yes ☐ No

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

Student:

TO BE COMPLETED BY PARENT OR GUARDIAN

EMERGENCY CONTACTS					
Mother/Guardian	Name		Father/Guardian	Name	
	Home Phone			Home Phone	
	Work Phone			Work Phone	
	Other			Other	

ADDITIONAL EMERGENCY CONTACTS					
1.		Relationship:		Phone:	
2.		Relationship:		Phone:	

Parent:

My child may carry and self-administer his/her asthma inhaler? ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No

My child may carry and is trained to self-administer his/her own EAI? ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No

- A new LHP School Asthma Plan and Medication Orders must be submitted each school year for an inhaler/EAI (Epinephrine Auto Injector).
- I understand that if any changes are needed on the School Asthma Plan, it is the parent's responsibility to contact the nurse.
- I understand that the permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that the student is not safely and effectively self-administering the medication.
- I have reviewed the information on this School Asthma Plan & Medication Orders and request/authorize trained staff to provide this care and administer (or to assist with the administration of) the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I authorize the exchange of medical information about my child's asthma between the LHP office and nurse.

Parent/Guardian Signature Date

This plan is intended to strengthen the partnership of families, healthcare providers and the school staff. It is based on the NHLBI Guidelines for Asthma Management.

For School-Registered Nurse's (RN) Use Only

A Registered Nurse has completed a nursing assessment and developed this Asthma Plan in conjunction with this student, their parent/guardian and their LHP. This Student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication. This student may carry and self-administer their medication: Yes _____ No _____ This plan has been reviewed/approved by a Registered Nurse.

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

Registered Nurse Signature **Date**