

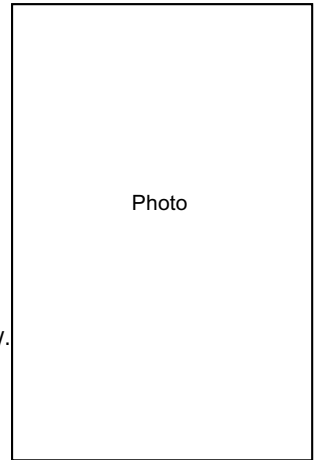
# School Nursing Asthma EAP

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

### TO BE COMPLETED BY PARENT / GUARDIAN

I, the parent/guardian of \_\_\_\_\_ date of birth \_\_\_\_\_

request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours  
And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes
4. I will assume responsibility for safe delivery of the medication to school
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I give permission for my child to self administer rescue medication if approved by physician
7. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization

**Please complete attached asthma action plan, or submit a current plan already on file in physician office.**

**I have discussed and developed a plan, with the school nurse, for appropriate support during school emergencies.**

Signature of  
Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_



# Asthma Action Plan for Home and School



Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Severity Classification  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

Asthma Triggers (list) \_\_\_\_\_

Peak Flow Meter Personal Best \_\_\_\_\_

## Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter \_\_\_\_\_ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School

Physical Activity  Use albuterol/levalbuterol \_\_\_\_ puffs, 15 minutes before activity  with all activity  when the child feels he/she needs it

## Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter \_\_\_\_\_ to \_\_\_\_\_ (between 50% and 79% of personal best)

Quick-relief Medicine(s)  Albuterol/levalbuterol \_\_\_\_ puffs, every 4 hours as needed

Control Medicine(s)  Continue Green Zone medicines

Add \_\_\_\_\_  Change to \_\_\_\_\_

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

## Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter \_\_\_\_\_ (less than 50% of personal best)

Take Quick-relief Medicine NOW!  Albuterol/levalbuterol \_\_\_\_ puffs, \_\_\_\_\_ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

**School Staff:** Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.

The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to “Take at School”.

Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

### Healthcare Provider

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

### Parent/Guardian

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

### School Nurse

The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_