USD 261
HAYSVILLE

1745 W. Grand
Haysville, Kansas 67060
Phone: 316-554-2200
Fax: 316-554-2230

Mary Parker, RN
District School Nurse

ASTHMA MEDICAL MANAGEMENT PLAN

Dear Parents or Guardian:

The enclosed Asthma care plan should be completed by the student's physician and parents/guardian. Please have the physician give guidelines on the treatment plan for when asthma symptoms occur, so that the school staff will be clear on what is to be done for your child.

Please also have the physician complete the attached form "Permission to Administer Medication." Please send inhaler in original labeled container from the pharmacy and include peak flow meter and spacer if one is to be used.

Each school year this plan must be completed by the student's physician and parents/guardian. If you have any questions or concerns, please call the Nurse or Health Aide in your child's school.

Thank you,
Mary Parker, R.N.
District School Nurse for Haysville Schools

Kansas Asthma Action Plan

Student Name: _____ Date of Birth___/___/___ Grade: _____

THE ABOVE STUDENT IS DIAGNOSED WITH ASTHMA. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER ASTHMA. PLEASE PLACE THIS FORM IN THE STUDENT'S MEDICAL FILE

Parent/Guardian Name: _____ Number where can be reached: (___) _____-_____

Student's Primary Care Provider: _____ Phone: (___) _____-_____

Daily Medication Plan

This is the student's daily medicine plan:

- The student has no asthma symptoms.
- The student can do usual activities.
- The student can sleep without symptoms.

Medicine/Dose		When to Give it
❑ Albuterol/Xopenex inhaler 2 sprays	OR	Every 4-6 hours **as needed** for wheezing/cough
❑ Albuterol/Xopenex solution 1 dosage		
❑ _____		_____
❑ _____		_____
❑ Albuterol/Xopenex inhaler 2 sprays	OR	nebulizer treatment 15-20 minutes before exercise, **only if needed**

Asthma Emergency Plan-What to do for increased asthma symptoms

Do this **first** when asthma symptoms occur:

Have the student take Albuterol inhaler 2 sprays OR one nebulizer treatment every 20 minutes up to 3 times. This is a **test dose** to see if the student's asthma improves with Albuterol.

What to do Next:	When to Do it:
❑ Have the student return to the classroom. ❑ Notify parents of students need for a quick relief medicine.	**Good Response to Test Dose of Albuterol** • The student's symptoms improve after 1-2 treatments. • The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness.) • Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours.
❑ Contact the parent or guardian. ❑ Contact the PCP for step-up medicine. ❑ _____	**Incomplete Response to Test Dose of Albuterol** • The student is experiencing mild to moderate symptoms (wheezing, coughing shortness of breath, chest tightness) after taking 3 treatments. • The student cannot do normal school activities.
❑ Seek emergency medical care in most locations, call 911. ❑ Call the PCP _____ ❑ _____ ❑ NOTE: Wheezing may be absent because air cannot move out of the airways.	**Poor Response to Test Dose of Albuterol** • The student does not feel better 20-30 minutes after taking the Albuterol. • The student has severe symptoms (coughing; extreme shortness of breath; skin reactions between the ribs **or** at the neck). • The student has trouble walking or talking. • The student's lips or fingernails are blue. • The student is struggling to breathe.

Trigger List:

- ❑ Chalk Dust
- ❑ Cigarette Smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: _____ _____
- ❑ Other: _____

_____ ___/___/___
Signature of Parent/Guardian Date

_____ ___/___/___
Signature of Physician Date

KS approval 07/15/09

(Permission Signatures on back)

Permission to Administer Medication
Haysville Public Schools
Health Services Department

Board Policy:
PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

Medications:

A. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
   a. Pupil's name
   b. Name of medication
   c. Dosage and directions for administration
   d. Date
   e. Prescribing physician's name

B. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.

_____ _____
Name of Student to Receive Medication Date of Birth

_____ _____
Print Name of Physician Phone

Name of Medication and Dosage to be given_____

For the Diagnosis of_____

Directions for administration and any other pertinent information:

_____

_____

Requested starting date of treatment_____ Expected duration of treatment_____

Request to administer the medication during regular school hours.

_____ _____
Signature of Parent/Guardian Physician's Signature

_____ _____ _____ _____
Phone Date Phone Date

_____ _____
Address Address