

## Haysville Public Schools Asthma Care Plan and Medication Order for School

**PARENT/GUARDIAN** to complete this portion and sign completed form.

Student Name:	Birthdate:
Parent/Guardian Name:	Phone:
Healthcare Provider Name:	Phone:
Triggers: <input type="checkbox"/> Weather (cold, wind) <input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Other:	
<input type="checkbox"/> Life Threatening Allergy – Specify:	

The medication listed below must be taken during school hours as directed by the health care provider. I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. / I hereby request that Haysville Schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I also certify that my child has received least one dose of the medication requested above and has not had any adverse reactions to it. / I further release Haysville Schools and school personnel from liability when my child self-carries and self-administers medication. / I approve of this Asthma Care Plan.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

<p><b>HEALTH CARE PROVIDER</b> to complete all items, <b>SIGN</b>, and <b>DATE</b> completed form</p>	<p>QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex  <input type="checkbox"/> Other: _____</p> <p>Common side effects: ↑heart rate, tremor <input type="checkbox"/> Have student use spacer with inhaler.                  Controller medication used at home: _____  <input type="checkbox"/> If temperature is below _____ degrees F, student should stay inside.</p>
<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
<p><b>GREEN ZONE:</b> No Symptoms Present</p> <ul style="list-style-type: none"> <li>- No current symptoms</li> <li>- Doing usual activity</li> </ul>	<p>Pretreat strenuous activity: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Student/Parent request</p> <p>Give QUICK RELIEF MED _____ minutes before activity</p> <p>Number of puffs: _____</p> <p><input type="checkbox"/> Repeat in _____ hours, if needed, for additional physical activity.</p>
<p><b>YELLOW ZONE:</b> Mild Symptoms</p> <ul style="list-style-type: none"> <li>- Trouble breathing</li> <li>- Wheezing</li> <li>- Frequent cough</li> <li>- Complains of tight chest</li> <li>- Not able to do activities, talking in complete sentences</li> <li>- Peak flow: _____ - _____</li> </ul>	<ol style="list-style-type: none"> <li>1. Stop physical activity</li> <li>2. Give QUICK RELIEF MED: Number of puffs: _____ Frequency: _____</li> <li>3. Stay with student and maintain sitting position</li> <li>4. <b>REPEAT QUICK RELIEF MED</b>, if not improving in 10-15 minutes with <input type="checkbox"/> 2 puffs / <input type="checkbox"/> 4 puffs / _____ puffs</li> <li>5. Student may return to normal activities, once symptoms are relieved</li> <li>6. <b>If symptoms do not improve in 15 minutes or worsen following quick relief medication, follow RED ZONE plan.</b></li> </ol>
<p><b>RED ZONE:</b> Severe Symptoms</p> <ul style="list-style-type: none"> <li>- Coughs constantly</li> <li>- Struggles to breathe</li> <li>- Trouble talking (only speaks 3-5 words)</li> <li>- Skin of chest and/or neck pull in with breathing</li> <li>- Lips/fingernails gray or blue</li> <li>- ↓ Level of consciousness</li> <li>- Peak flow &lt; _____</li> </ul>	<ol style="list-style-type: none"> <li>1. Give QUICK RELIEF MED: # of puffs: _____ - Refer to anaphylaxis plan if student has life-threatening allergy</li> <li>2. Call 911</li> <li>3. Stay with student and remain calm, encouraging slower, deeper breaths.</li> <li>4. Notify parents/guardians</li> <li>5. If symptoms do not improve, <b>REPEAT QUICK RELIEF MED</b>: <input type="checkbox"/> 2 puffs or <input type="checkbox"/> 4 puffs every 5 minutes until EMS arrives.</li> </ol>

**PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)**

- Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.
- Student understands proper use of asthma medications, and, in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.
- Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Print Provider Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone # / Fax #