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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

<p>This is the student's daily medicine plan:</p> <ul style="list-style-type: none"> • The student has no asthma symptoms. • The student can do usual activities. • The student can sleep without symptoms. 	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">Medicine/Dose</th> <th style="text-align: center; border-bottom: 1px solid black;">When to Give it</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR <input type="checkbox"/> Albuterol/Xopenex solution 1 dosage </td> <td style="border-bottom: 1px solid black;"> Every 4-6 hours as needed for wheezing/cough </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> _____ </td> <td style="border-bottom: 1px solid black;"> _____ </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR _____ </td> <td style="border-bottom: 1px solid black;"> nebulizer treatment 15-20 minutes before exercise, only if needed </td> </tr> </tbody> </table>	Medicine/Dose	When to Give it	<input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR <input type="checkbox"/> Albuterol/Xopenex solution 1 dosage	Every 4-6 hours as needed for wheezing/cough	<input type="checkbox"/> _____	_____	<input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR _____	nebulizer treatment 15-20 minutes before exercise, only if needed
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Asthma Emergency Plan-What to do for increased asthma symptoms

<p>Do this first when asthma symptoms occur:</p>	<p>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.</p>	<p>Trigger List:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chalk Dust <input type="checkbox"/> Cigarette Smoke <input type="checkbox"/> Colds/Flu <input type="checkbox"/> Dust or dust mites <input type="checkbox"/> Stuffed animals <input type="checkbox"/> Carpet <input type="checkbox"/> Exercise <input type="checkbox"/> Mold <input type="checkbox"/> Ozone alert days <input type="checkbox"/> Pests <input type="checkbox"/> Pets <input type="checkbox"/> Plants, flowers, cut grass, pollen <input type="checkbox"/> Strong odors, perfume, cleaning products <input type="checkbox"/> Sudden temperature change <input type="checkbox"/> Wood smoke <input type="checkbox"/> Foods: _____ <input type="checkbox"/> Other: _____
<p style="text-align: center;">What to do Next:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Have the student return to the classroom. <input type="checkbox"/> Notify parents of students need for a quick relief medicine. 	<p style="text-align: center;">When to Do it:</p> <p style="text-align: center;">Good Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	
<ul style="list-style-type: none"> <input type="checkbox"/> Contact the parent or guardian. <input type="checkbox"/> Contact the PCP for step-up medicine. <input type="checkbox"/> _____ 	<p style="text-align: center;">Incomplete Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	
<ul style="list-style-type: none"> <input type="checkbox"/> Seek emergency medical care in most locations, call 911. <input type="checkbox"/> Call the PCP _____ <input type="checkbox"/> _____ <input type="checkbox"/> NOTE: Wheezing may be absent because air cannot move out of the airways. 	<p style="text-align: center;">Poor Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	

Signature of Parent/Guardian

____/____/____
Date

Signature of Physician

____/____/____
Date

**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