DEPARTMENT OF HEALTH
Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

PHILADELPHIA ALLIES AGAINST ASTHMA
Giving Children Freedom to Breathe

Name | Birth Date | Effective Date

School | Parent/Guardian | Parent's Phone

Doctor/Nurse's Name | Doctor/Nurse's Office Phone

Emergency Contact After Parent | Contact Phone

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other: _____

TAKE THESE MEDICINES EVERY DAY

Child feels good:
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXCEPTION USE THIS MEDICINE:

IF NOT FEELING WELL

TAKE EVERYDAY MEDICINES AND (ADD) THESE RESCUE MEDICINES

Child has *any* of these:
- Cough
- Wheeze
- Tight Chest

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! TAKE THESE MEDICINES

Child has *any* of these:
- Medicine is not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

Peak flow below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature | Date

Health Care Provider Signature

☐ **It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the NYC Childhood Asthma Initiative

Adapted forms the NHLBI

Printed 10/2005

Schuylkill Haven Area School District
Health Services
Authorization for Administration of Inhaled Asthma Medication
(Use a separate authorization form for each medication)

School: _____
Student's Name: (First/M/Last) _____

Sex: (please circle) Female Male Birthdate: ____/____/____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:
Physician's Name: _____
Telephone Number: _____ Fax Number: _____
Emergency Contact Number: _____
Diagnosis: _____
Name of Medicine: _____
Form: _____ Dose: _____

Is the child knowledgeable about his/her asthma medication? ☐ Yes ☐ No
Has the child demonstrated the proper technique in administering medication? ☐ Yes ☐ No
Medicine is administered daily. Time: _____ ☐ Yes ☐ No
Medicine is administered when needed. Indications: _____
_____
If needed, how soon can administration of medicine be repeated? _____
The medication cannot be repeated more than _____
Side effects: _____
_____
Comments: _____
_____

( ) I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.
( ) It is my professional opinion that _____ should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: _____

FOR COMPLETION BY PARENT/GUARDIAN:
Mother's Name: _____
Father's Name: _____
Mother's Work Telephone: _____ Father's Work Telephone: _____
Home Telephone: _____ Cell Phone #: _____ Emergency #: _____

Is the child authorized to carry and self-administer inhaled asthma medication? ☐ Yes ☐ No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers. I hereby release the Schuylkill Haven Area School District and all its employees from any and all liability for damages my child may suffer as a result of the request, I acknowledge that the School District bears no responsibility for ensuring that the medication is taken.

Parent/Guardian Signature & Date: _____

SCHUYLKILL HAVEN AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

ASTHMA HISTORY FORM

What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often

What herbal remedies, if any, does this student take for asthma? _____

_____

Does this student use any of the following aids for managing asthma?

- ☐ peak flow meter (personal best if known _____)
- ☐ holding chamber ☐ spacer ☐ holding chamber w/mask
- ☐ other: _____

Please check special needs related to your child's asthma:

- ☐ physical education class ☐ recess ☐ animals in classroom
- ☐ avoidance of certain foods ☐ field trips ☐ access to water
- ☐ transportation to and from school ☐ other
- ☐ observation of side effects from medications

If you checked any of the above boxes, please describe needs:

_____

_____

Has this student had asthma education? ☐ yes ☐ no
Would you like information about asthma education for: ☐ student ☐ self

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

SCHOOL ASTHMA POLICY

Purpose: To support the academic performance and improve the health status of students with asthma.

Rationale: Asthma is the leading cause of school absenteeism for children with chronic illness. Research supports that when children are taught how to take care of their disease, and adults – both at school and at home, and learn ways to prevent asthma episodes and emergencies, the children's academic performance improves and they participate more actively in the learning process.

Schools can help students control their asthma by helping them follow individualized asthma action plans, by minimizing students' exposure to allergens and other triggers by responding appropriately to students' asthma episodes.

Aim: The aim of this policy is to set out clearly the roles and responsibilities of the parents and school in relation to children with asthma in school in accordance with Act 187 signed into law 12/1/04. Act 187 permits school children with a physician's diagnosis of asthma, medication orders, parental permission, and who demonstrate responsible behavior to carry and self-administer their medication via an asthma inhaler.

All students with asthma are required to have an updated asthma action plan at school which is renewed each year. With parental permission the plan will be shared with appropriate school personnel. Completion of an Asthma History form is also required.

When taking inhaled medications at school you and your child's health care provider may choose one of 2 options:

1. Assist students with medications in nurse's office, or
2. Student may carry own medication, if responsible and specific requirements are met.

Students without an emergency action plan will be provided first aid according to "Standard Protocol for Students without a Personal Asthma Action Plan." Copies of this protocol will be given to all PE teachers, classroom teachers, and other personnel working with the student.

SELF-ADMINISTRATION OF ASTHMA MEDICATION AUTHORIZATION PROCEDURE

When a health care provider, parent/guardian, student and school nurse agree that self-administration of asthma or other medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately.

An authorization for administration of inhaled asthma medication form must be completed by the prescribing health professional and parent/guardian and returned to the school nurse. (Forms can be obtained in the nurse's office.)

ORDERS MUST BE RENEWED ANNUALLY OR WHENEVER MEDICATION, DOSAGE, OR ADMINISTRATION CHANGES.

The parent / guardian family must provide to the school health office:

A written order by health care provider (could be in the form of a signed AAP) and authorization for administration of inhaled asthma medication form. (Forms can be obtained in nurse's office.)
Written authorization by the parent/guardian. (Forms can be obtained in nurse's office).
The order is to include the name of the drug, the dose, the times when the medication is to be taken and the diagnosis or reason the medication is to be taken.
The inhaler and/or other medication in a container appropriately labeled by a pharmacist or the health care provider.

The student will need to:

Demonstrate competency in taking his/her medication safely
Demonstrate appropriate asthma management and self-care skills
Appropriately complete and sign the self-administration student agreement
(Forms can be obtained in nurse's office.)

The licensed school nurse will need to:

Determine asthma severity level as indicated on an AAP, and assess level of asthma control
Assure the student understands what is asthma, early and late warning signs/symptoms, peak flow usage as appropriate, what to do to prevent and relieve symptoms, the concept of good control, asthma management steps, how to use their asthma action plan, the difference between controller and reliever medication, appropriate self-care skills, and can demonstrate appropriate medication technique/competency (including knowing how to tell time and decide when to take their medications).
Intervene on the student's behalf by communicating with the student's parent/guardian and health care provider as needed in order to promote better asthma control and acquisition of asthma self-care skills.