Student Asthma/Allergy Action Plan

Richmond County School System

(This Page To Be Completed By Physician)

Student Name: _____ Date Of Birth: ____/____/____ (MONTH) (DATE) (YEAR)

☐ Exercise Pre-Treatment: Administer inhaler (2 Inhalations) 15-30 minutes prior to exercise. (e.g. PE, recess, etc).

☐ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
☐ Levalbuterol (Xopenex HFA)
☐ Pirbuterol inhaler (Maxair)
☐ Use inhaler with spacer/valved holding chamber
☐ May carry & self-administer inhaler (MD)
☐ Other: _____

Asthma Treatment

Give quick relief medication when student experiences asthma symptoms, such as coughing, wheezing or tight chest

☐ Abuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Pirbuterol (Maxair) 2 inhalations
☐ Use inhaler with spacer/valved holding chamber
☐ May cary & self-administer inhaler (MD)
☐ Albuterol inhaled by nebulizer (Proventil, Ventolin, AccuNeb)
☐ .63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 mL
☐ Levalbuterol inhaled by nebulizer (Xopenex)
☐ 0.3 mg/3 mL ☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL
☐ Other: _____

Closely Observe the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are improved, student may return to Classroom <u>after</u> notifying parent/guardian
- No improvement in symptoms, repeat the treatment and notify parent/guardian immediately
- *<u>If student continues to worsen CALL 911 and Initiate the Richmond County Schools' Emergency Response to LifeThreatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol</u>*

Anaphylaxis Treatment

Give epinephrine when student experiences allergy Symptoms, such as tongue swelling, throat closing, change in voice, faintness, difficulty breathing (chest or neck "sucking in), lips or fingernails turning blue, or trouble talking (shortness of breath).

☐ EpiPen® 0.3 mg
☐ EpiPen® jr. 0.15 mg
☐ Twinject™ 0.3 mg
☐ Twinject ™ 0.15 mg
☐ Adrenaclick® 0.3 mg
☐ Adrenaclick® 0.15 mg
☐ Other: _____
☐ May carry & self-administer epinephrine

CALL 911 <u>After</u> Giving Epinephrine, Closely Observe the Student

- Notify parent/guardian immediately
- *<u>Even</u> if student improves, the student Should be observed for recurrent Symptoms of anaphylaxis in an emergency medical facility*
- *<u>If student does not improve or continues to worsen, consider a second dose of epinephrine and initiate Life Threatening Allergic Reaction Protocol</u>*

☒ This student has a medical history of asthma and/or anaphylaxis and I have reviewed the use of the above-listed medication(s). If Medications are self-administered; the school staff <u>must</u> be notified.

<u>Additional information:</u> *(i.e asthma triggers, allergens)* _____

_____

Physician name: *(please print)* _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Reviewed by school nurse/nurse designee: _____ Date: _____

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

Student's Name: _____

Teacher: _____ Grade: _____

I hereby request that the _____ School System, through the principal or designee, supervise/assist in the administering of medication to my child according to the instructions contained on the statement below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of Medication: _____

Dosage and Time to be Given: _____

Stop Medication on: _____

Physician Name: _____ Physician Phone: _____

I release the school board, the school, and any school employee from any liability for administering this medication.

_____ _____

Parent/Legal Guardian Signature Date

Home Phone: _____ Work Phone: _____ Pager/Cell Phone: _____

To be completed by healthcare provider for prescription medications given for more than two weeks.

Condition/Illness Requiring Medication: _____

Possible Side Effects if any: _____

_____ _____

Signature of Healthcare Provider Date

Written Authorization for Self-Administration of Asthma Medication by Minor Children at School

Student Name: _____ Date of Birth: _____ Grade: _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of asthma medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff

I take sole responsibility for:

- the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication
- ensuring the student always carries his/her asthma medication on his/her person
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication
- informing school staff in writing of any changes in the student's treatment or asthma management
- informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian
- coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff)

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release the _____ School System and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her asthma medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

_____ _____

Physician's Signature Date