SHEPHERD SCHOOLS ASTHMA CARE PLAN AND ORDER FOR SCHOOL

Student: _____ DOB: _____ School: _____ Grade: _____

Asthma Triggers (List): _____

Severity Classification: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

PARENT/GUARDIAN COMPLETE AND SIGN

Parent/Guardian Name(s): _____Phone Number(s): _____
Health Care Provider: _____ Phone Number: _____

- **I understand that this form needs to be completed annually and updated with any changes during the school year.**
- **By signing this document, I give permission for this Health Care Provider to share information about this medication/procedure with the Registered Nurse.**
- **I assume full responsibility for providing the school with the prescribed medication and supplies necessary for treatment of my child's asthma.**
- **I am aware that 911 may be called if my child's symptoms are severe and a quick relief inhaler is not available at school or if the plan has been followed and my child is not responding to treatment.**
- **I acknowledge that the school district may not incur liability as a result of any injury arising from the administration of medication and that the parent shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act of omission, that is the result of gross negligence, willful and wanton conduct, or an intentional tort.**
- **I approve of this plan for my child.**

Parent/Guardian Signature: _____ Date:_____

HEALTH CARE PROVIDER ORDER

Please check: **☐ Student needs supervision to use inhaler.** **☐ Student understands the proper use of asthma medication and may administer the medication without direct supervision (Carries own inhaler).**	**Quick Relief (Rescue) Medication: _____** **Controller Medication used at home: _____** **☐ Spacer recommended (if available)**
IF YOU SEE THIS:	**DO THIS:**
<u>GREEN ZONE: Doing Well</u> • **No cough, wheeze, chest tightness, or shortness of breath during the day or night.** • **Can do usual activities.**	**Pretreat strenuous activity (PE, long recess, sports event, etc.)** **☐ Not required** **☐ Routine-15 min before activity** **☐ Per parent/student request** **Med/Dose/Time:**
<u>YELLOW ZONE(Caution): Asthma is getting worse</u> • **Frequent cough, wheeze, chest tightness, shortness of breath, and complains of difficulty breathing.** • **Able to talk in complete sentences but not able to do activities.**	**1. Stop physical activity.** **2. Quick relief inhaler: _____** **☐ 2 puffs** **☐ 4 puffs** **3. Student should be monitored closely.** **4. If not improving in _____, repeat quick relief med:** **☐ ___ puffs every _____ up to 1 hour** ***Notify parent/guardian and School Nurse if not already present.** **5. May return to normal activities once symptoms are relieved.** ***IF SYMPTOMS DO NOT IMPROVE OR WORSEN FOLLOW "RED ZONE"**
<u>RED ZONE: Emergency!! Get Help Now</u> • **Coughing constantly, struggling to breathe, skin of chest and/or neck pull in with breathing, lips/fingernails gray or blue, and/or decreased level of consciousness.** • **Difficulty talking (only speaks 3-5 words) and unable to do usual activities.**	**1. Quick relief inhaler: _____** **☐ 4 puffs** **☐ 6 puffs** **2. Call 911** **3. Call parent/guardian and School Nurse if not already present.** **4. Stay with student- remain calm and encourage slow, deep breaths.** **5. If symptoms not improving or continuing to worsen, repeat quick relief inhaler dose _____ puffs every _____ minutes until symptoms improve or EMS arrives.**

Other instructions for this student: _____

Health Care Provider Signature: _____Date: _____