

Loudoun County Public Schools Asthma Action Plan/Physician's Order

STUDENT'S NAME: _____ DOB: _____ GRADE: _____
 School: _____ Homeroom Teacher: _____ Room # _____
 Transportation: Walker _____ Car _____ Bus # _____

Identify asthma triggers (Circle each that applies to this student)

- | | |
|------------------------|-------------|
| Exercise | Pollens |
| Respiratory infections | Molds |
| Change in temperature | other _____ |

Asthma Medication Required at School: If more than one medication is to be given at same time, list in order to be given.

Medication	Amount	When to Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

SEEK EMERGENCY MEDICAL CARE (911) IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No Improvement 15-20 minutes after initial treatment.
- Breathing is hard and fast with difficulty walking, talking or eating.
- Lips or fingernails are gray and blue accompanied by fatigue, weakness.
- Difficulty breathing with chest and neck pulled in.
- Audible wheezing may have subsided.

Time Interval for Repeating Dosage:

If symptoms not relieved after initial dose: _____
 If symptoms reoccur before next dose is due: _____

I have instructed this student in the proper use of his/her medication. It is my professional opinion student SHOULD/SHOULD NOT carry his/her inhaled medication.

Physician's Signature: _____ Date: _____ Phone Number: _____
 Physician's Printed Name: _____ Fax Number: _____

Parent/Guardian Section

Emergency Information: Parent/Guardian Names _____
Telephone Number: Mother Father **Emergency Contact with phone #**
 Home: _____ _____ _____
 Work: _____ _____ _____

Parent's signature gives permission for principal's designee to follow this plan, administer prescribed medicine, and contact physician if necessary. _____
(Parent/Guardian Signature Required) Date

**Loudoun County Public Schools
Asthma Individual Health Care Plan**

Student's Name _____ **Date of Birth** _____

Teacher's Name _____ **Grade** _____

Physical education days/times: _____

Symptoms of an asthma attack might include:

- | | |
|--------------------|-------------------------------------|
| Coughing | Gasping for air |
| Wheezing | Color changes (pale or blue) |
| Tightness in chest | Child states "difficulty breathing" |
| Other _____ | |

If symptoms of an attack are present or _____ states that he/she feels an attack coming on:

- a. **DO NOT SEND STUDENT TO CLINIC ALONE.**
- b. If student cannot walk or talk in complete sentences, then the teacher should contact the clinic.
- c. Have student sit upright and sip water.
- d. Administer prescribed medication by inhaler or nebulizer.
- e. Reassure student and attempt to keep him/her calm and breathing slowly and deeply.
- f. Student should respond to treatment within 15-20 minutes.
- g. If no change, then contact the parent.
- h. **IF STUDENT'S BREATHING BECOMES SIGNIFICANTLY WORSE, CALL 911:**
 - Shoulders kept raised
 - Beaded perspiration
 - Blue lips, fingernails, or skin
 - Labored breathing
 - Pale
 - Skin between ribs or at base of neck collarbone retracts as student breathes

Individual Considerations

- Self pace for physical activities
- Inhaler before physical activities
- Physician approval for student to carry inhaler
- Restrictions ordered by physician: _____
- Other (Specify, i.e. recent hospitalization or ER visit): _____

Bus

Transportation will be alerted to student's asthma.

The student will carry an inhaler on the bus per physician order: YES NO

An inhaler can be found in: Backpack waist pack other _____

Parent Signature/Date

Clinic Staff and RN Signature/Date

Loudoun County Public Schools
Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Asthma Action Plan)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic specialist.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering the medication, I will report to the school nurse/health clinic specialist or another appropriate adult if the nurse/health clinic specialist is not available or present.

Student's Signature Required

Date