



# ASTHMA / INHALER USE CARE PLAN & AUTHORIZATION FOR MEDICATION

## TO BE COMPLETED BY PARENT:

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
 Parent/Caregiver \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name of Physician \_\_\_\_\_ Office phone number \_\_\_\_\_

### What triggers your child's asthma attack: (Check all that apply)

- Illness  Cigarette or other smoke  Food \_\_\_\_\_  
 Emotions  Exercise  Allergies  cat  dog  dust  mold  pollen  
 Weather changes  Chemical odors  Other \_\_\_\_\_

### Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

- Cough  "Tightness" in chest  Rubbing chin/neck  
 Shortness of breath  Breathing hard/fast  Feeling tired/weak  
 Wheezing  Runny nose  Other \_\_\_\_\_

## TO BE COMPLETED BY PHYSICIAN:

The child's asthma is:  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise-Induced

Symptoms	Peak Flow &/OR Monitoring	Treatment		
		Medication	How much	When
<b>WELL</b> • Usual medications control asthma • No cough or wheeze • Able to sleep through the night • No rescue meds needed • No activity restrictions (PE & recess are okay)	<b>GREEN ZONE</b>  Personal Best = _____  _____ to _____	<b>Relievers/Rescue</b>		
		<input type="checkbox"/> Albuterol (with spacer)	2 puffs 1 minute apart every 4-6 hours as needed	<input type="checkbox"/> 2 puffs 5-15 min before physical activity
		<input type="checkbox"/> Other _____		
		<b>Controllers</b>		
		<input type="checkbox"/> Inhaled Corticosteroid _____		
		<input type="checkbox"/> Advair		
		<input type="checkbox"/> Symbicort		
<b>SICK</b> • Needs reliever medications more often • Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities	<b>YELLOW ZONE</b>  _____ to _____	<b>Leukotriene Modifier:</b> <input type="checkbox"/> Singulair <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____		
		1. <input type="checkbox"/> Continue daily controller medications 2. <input type="checkbox"/> Give albuterol 2-6 puffs (one minute between puffs) with spacer, wait 20 min. 3. <input type="checkbox"/> If no improvement, repeat 2-6 puffs. Wait 20 minutes. <b>Call parent and/or MD</b>  <b><u>If no improvement, CALL 911</u></b>		
		<b>If child returns to Green Zone:</b> <input type="checkbox"/> Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days <input type="checkbox"/> No physical exercise <input type="checkbox"/> Physical exercise as tolerated i.e. PE & recess at school		
<b>EMERGENCY!</b> • Reliever medications do not help • Very short of breath, difficulty breathing • Constant cough	<b>RED ZONE</b>  < _____	<input type="checkbox"/> Give albuterol 2-6 puffs (with spacer) NOW! May repeat once after 20 minutes <b><u>If there is no improvement, call parent and/or 911</u></b>		
		<b><u>Call 911 immediately if:</u></b> <input type="checkbox"/> Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol <input type="checkbox"/> Trouble talking or walking <input type="checkbox"/> Lips or fingernails are gray or blue <input type="checkbox"/> Chest or neck is pulling in with breathing		

### PATIENT/STUDENT INSTRUCTIONS: (check all that apply)

- Student has been instructed in the proper use of all his/her asthma medications  
 Student needs supervision or assistance to use his/her inhaler  
 Student should **NOT** carry his/her inhaler while at school  
 In my opinion, the student can carry and use his/her inhaler at school and for sports (An additional inhaler, to be kept as backup, may be kept in the clinic)

HEALTH CARE PROVIDER SIGNATURE \_\_\_\_\_

PLEASE PRINT PROVIDER'S NAME \_\_\_\_\_

DATE \_\_\_\_\_

Current school year \_\_\_\_\_

I give my permission for school personnel to follow this plan, administer medication and care to my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring device. I approve this Asthma Management Plan for my child. I hereby request Immanuel Christian School personnel to permit the student identified above to use and inhaler in school as prescribed. I agree to release, indemnify, and hold harmless ICS and any of their staff members and clinic volunteers or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student with the inhaler, provided ICS personnel are following physician instructions.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

## PARENT INFORMATION ABOUT INHALER PROCEDURES

1. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
2. Parents/guardians are responsible for submitting a new Inhaler Care Plan form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration. The form must be filled out and signed by parent/guardian and Licensed Health Care Provider (LHCP).
3. **The parent or guardian must transport medications to and from school.**
4. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry medications (inhaler, Epi Pen). If the student self carries, it is advised that a backup medication be kept in the clinic. **In order to self carry the inhaler, the LHCP must check the 2 boxes that state the student has been instructed in the proper use of the inhaler, and that they can carry the inhaler at school and for sports.**
5. If the student has approval from the physician to carry the medication for sports, it is the student's responsibility to bring it to practices and games. If the student does not have the inhaler with them, the coach may elect for that child to not practice or travel with the team to the game.
6. A Licensed Health Care Provider (LHCP) may use office stationary, prescription pad or other appropriate documentation in lieu of completing the attached form. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
  - a. Student name
  - b. Date of Birth
  - c. Diagnosis
  - d. Signs or symptoms
  - e. Name of medication to be given in school
  - f. Exact dosage to be taken in school
  - g. Route of medication
  - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
  - i. Sequence in which two or more medications are to be administered
  - j. Common side effects
  - k. Duration of medication order or effective start and end dates
  - l. LHCP's name, signature and telephone number
  - m. Date of order
7. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
8. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.