School Asthma Action Plan

Student's Name: _____ Date of Birth: _____ Date form completed: _____
School Name: _____ Teacher: _____

☐ For exercise: _____ Inhaler _____ puffs 15-30 minutes before exercise.
Immediate action is required when the above-named student exhibits any of the following signs of an asthma attack:
Repetitive Cough Shortness of Breath Chest tightness Wheezing/Retractions Inability to speak in sentences

☐ Steps to take during an asthma flare:

1. Give emergency asthma medications as listed below:

	Quick Relief Medication	Dose	Frequency
☐	Albuterol Inhaler	2-4 puffs with spacer	Every 2-4 hours prn for cough
☐	Albuterol Neb		
☐	Xopenex Neb		
☐	Other Medications		

Reassess in 10-15 minutes and reclassify the child according to the following parameters:

	Cough	Respiratory Rate	Accessory muscle use or retractions	Work of breathing or shortness of breath
Normal	None to occasional	**Normal Rate** 2-4 y/o <32 5-6 y/o <28 7-14 y/o <25 >15 y/o <22	None	• Normal • Easily speaks in sentences
Asthma symptoms continue	Very frequent to constant	> normal for age	Present	Speaks in short sentences, or only in words

2. If the child is:
   - Normal – the child may return to the classroom
   - Continues with asthma symptoms – continue with the medication listed in number 1 above every 15-30 minutes until EMS arrives
3. Activate EMS (call 911) IF the student has ANY of the following symptoms:
   - Lips or fingernails are blue or gray
   - The student is too short of breath to walk, talk, or eat normally
   - The student gets no relief within 10-15 minutes of quick relief medicines OR the child has any of the following signs:
     - Persistent chest and neck pulling in with breathing
     - Child is hunching over
     - Child is struggling to breathe
     - Child's asthma symptoms continue as outlined in the table above.

☐ I certify that this child has been trained in the use of the listed medication, and is judged by me to be:
_____capable of carrying and self-administering the listed medication(s),
_____NOT capable of carrying and self-administering the listed medication(s).

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

The child should notify the school staff if one dose of the asthma medication fails to relieve asthma symptoms for at least 3 hours.

_____ _____ _____
Physician Name (PRINT) Physician Signature Date

_____ _____ _____
Parent Name (PRINT) Parent Signature Date

Reviewed by: _____ Date: _____

*Refer to 504 coordinator if appropriate

Request for Administration of Medication

Medications can be administered during school hours, if necessary, with this completed form for any over the counter (OTC) or prescription medications.

I understand that:

- All medications must be approved by the United States (US) Food and Drug Administration.
- **Prescription medications** must be from a US pharmacy in the original prescription labeled container, which states the student's name, date, name of licensed practitioner, name of the medication, medication strength, route and frequency of medication, instructions for use and name of pharmacy filling the prescription. A licensed practitioner's signature is required on this form within 10 school days of parent or guardian's request for administration. We recommend that you ask the pharmacy for three labeled prescription containers: one for home, one for the school clinic and one for field trips. Expired medication will not be administered.
- **Over the counter medications** must be distributed by a US manufacturer/lab and in the original container with an intact manufacturer's label. Only parent or guardian signature is needed on this form *unless* the medication request is for more than 10 consecutive school days and/or at the school's discretion. Expired medication will not be administered.
- All medication must be BROUGHT TO THE SCHOOL CLINIC BY PARENT/GUARDIAN. Students may not have medication in their possession, unless considered an emergency medication. Completion of this form, FCS Authorization to Carry Emergency Medication form and appropriate care plan is required in such circumstances.
- Parent/Guardian must provide the medication, related supplies, or equipment along with specific instructions for administration.
- It is the parent or guardian's responsibility to inform the school of any pertinent changes in their student's medication and/or health condition.
- The school nurse is not always available to assist in administering medication, and the student may be assisted by an FCS employee designated by the school administration.
- With the completion of this form, FCS employees may contact my child's health care provider and/or pharmacy to acquire clarification concerning this medication.
- Medications must be PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.
- Any student possessing a prescription or OTC medication not in accordance with these guidelines will be considered in violation of FCS Board Policy JCDAC: Student Drug Use and shall be subject to the discipline set forth in FCS Code of Conduct.

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Medication Name: _____ **Dose:** _____

Route: _____ **Time(s) of Administration:** _____

Allergies: _____ **Stop Medication on:** _____

**I hereby give my permission for my child to receive this medication at school. I hereby release and discharge the Forsyth County Board of Education and its employees and officials from all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release officials from any liability because of any injury or damage which might occur.*

_____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

_____

Home Phone Work Phone Cell phone

To be completed by Licensed Practitioner (as required)

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Licensed Practitioner's Signature: _____ **Date:** _____

Licensed Practitioner's Name Printed: _____ **Phone:** _____

Parent/Guardian Picked Up Medication: _____ Date: _____

Parent Signature: _____ Nurse: _____ Date: _____

Authorization For Students to Carry Emergency Medication

FCS acknowledges that a student who carries their emergency medication may not be able to self-administer their own emergency medication, in which school personnel are authorized to administer.

_____needs to carry the medication listed below prescribed by their physician (inhaler, epinephrine auto injector, insulin, diabetic supplies, emergency seizure medication and/or other emergency prescription medications.

The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication if able.

It is preferable that a second prescription inhaler, epinephrine auto injector, insulin, diabetic supplies, emergency seizure medication and/or other emergency prescribed medication be kept in the school clinic.

Name of Medication: _____

Practice Name | Address | Telephone Number

Physician's Name (Please Print) | Credentials

Physician's Signature | Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the school nurse each time I take my medication.

Student's Signature _____ *Date* _____

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry, and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above-named student administers his/her own medication.

Parent/Guardian Name (Please Print) | Parent/Guardian Signature | Date