Austintown Local Schools
700 South Raccoon Rd.
Austintown,OH 44515
330.797.3900
330.792.8625 Fax

ASTHMA

Dear Parent/Guardian:

You have indicated that your child has asthma. Please complete the attached SCHOOL ASTHMA RECORD. If your child requires medication for his/her asthma, please have your physician complete the attached SCHOOL ASTHMA ACTION PLAN including a parent signature and refer to our school policy on medication administration (attached). Return these forms as soon as possible to the school clinic.

The information requested is confidential and will only be shared with appropriate personnel. The information that you relate to us will enable us to take immediate and appropriate action in caring for your child. **It is the parent/guardian's responsibility to inform the bus driver of your child's condition.**

Students are permitted to carry and administer their own Emergency Rescue Medication (Inhaler) provided that the physician AND parent authorize the student to do so on the SCHOOL ASTHMA ACTION PLAN. We do request, however, that a spare inhaler be kept in the school clinic should your child forget to bring his/her inhaler to school and not have it on his/her person when needed.

It is the parent/guardian's responsibility to communicate to the school any changes in their child's condition, treatment or medication. This form also needs to be updated on a yearly basis.

Thank You,

Austintown School Nurses

ADMINISTRATION OF MEDICATION TO STUDENTS DURING SCHOOL HOURS

All medication should be given at home when possible. The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. In the event that it is necessary for a student to receive medication during the school day, the following requirements must be met prior to the administration of medication:

- **PRESCRIPTION MEDICATION:** An Administration of Medication Request Form must be completed and signed by both the physician and parent/guardian.
- **OVER-THE-COUNTER MEDICATION** (Nonprescription): An Administration of Medication Request form must be completed and signed by the parent/guardian.
- The first dose of any new medication will not be administered at school in case of an allergic reaction.
- It is the student's responsibility (age appropriate) to report to the clinic at the designated time to receive the medication ordered.
- All medication MUST be brought to school by the parent/guardian. Students are not permitted to carry or transport medication unless previously authorized by the school, physician, and parent/guardian and is an Emergency medication (i.e.; Inhaler, EpiPen).
- All Prescription medication must be labeled appropriately by the pharmacist or physician and in its original container. The label must state the student's name, dosage, and time(s) to be taken and must match the Administration of Medication Request form.
- All Nonprescription medication must also be in its original container and labeled with a permanent marker indicating the child's name. Medication not in its original container will not be administered to the student.
- The recommended dosage on the box of the nonprescription medication will be reviewed and compared to the parent/guardians request. If the dosage exceeds amount recommended on the medicine container/box, it must be requested by a physician's order on an Administration of Medication Request form.
- The principal or appointed representative will supervise the administration of the medication in the absence of the school nurse.
- Any change to the medication must be submitted on a new Administration of Medication Request form. If a prescriptive medication is to be discontinued, a written note must be provided by the practitioner.
- New Request forms must be submitted for each new school year and for each medication.

Parent(s)/Guardian(s) MUST pick up any unused medication. Medication will not be sent home with the child unless previously authorized and is an emergency medication. All medications not retrieved will be disposed of according to Ohio Revised Code.

School Asthma Action Plan

Name	Birth Date	Address
Emergency Contact	Phone	Cell

Triggers ❑ Mold/Pollens ❑ Animals ❑ Colds ❑ Dust ❑ Exercise ❑ Smoke ❑ Weather ❑ Fragrance

Green Zone: Doing Well

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night
- No early warning signs
- Peak Flow Meter if used: 80-100% of personal best _____

School Action: Follow actions in marked boxes below for exercise induced asthma

❑ **Medication Before Exercise** ❑ **Medication Before Recess** ❑ **Use routinely every_____ hours**
Medication with spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex
Medication without spacer: ❑ Maxair Autohaler
Dose: puffs **When:** 10-15 minutes before listed activity **Start Date:** School Year **Stop Date:** School Year

Yellow Zone: Getting Worse
(mild trouble breathing)

- Cough, wheeze, chest tight
- Problems working/ playing
- Early warning signs
- Shortness of breath
- Peak Flow Meter if used: 50 to 80% of personal best _____

School Actions: Follow actions in marked boxes below

Take Quick-Relief Medication	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex Without spacer: ❑ Maxair Autohaler	_____ puffs	Student report of symptoms	School Year	School Year
Nebulizer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑Xopenex	_____ Unit Dose	Student report of symptoms	School Year	School Year

❑ **If symptoms improve after 10-15 minutes: Return to normal activity**
❑ **If symptoms do not improve after 10-15 minutes: Give quick relief medication again and call parents**
❑ **If symptoms improve after the second 10-15 minutes: Return to normal activity and call parents**
❑ **If symptoms do not improve after the medication is repeated: Call EMS (911), School RN and parents**
❑ **If symptoms get worse at anytime: Call EMS (911), School RN and Parents**
❑ **Report frequent use of quick relief medications (twice a day for 3 days, not for exercise) to the School RN and Parents**

Red Zone:
Medical Alert
(severe trouble breathing)

- Cannot stop coughing
- Breathing fast
- Flaring nostrils
- Medication not helping
- Getting worse, instead of better
- Trouble walking or talking from shortness of breath
- The skin between the ribs and above the collarbone pulls in or retracts
- Lips or fingernails are blue

School Actions:
1. Call EMS (911) IMMEDIATELY
2. GIVE QUICK-RELIEVER MEDICATION AND CONTINUE EVERY 15 MINUTES UNTIL EMS (911) ARRIVES
3. Call School RN and Parents

Take Quick-Relief Medications	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex Without spacer: ❑ Maxair Autohaler	_____ puffs	Student report of or observation of symptoms.	School Year	School Year
Nebulizer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑Xopenex	_____ Unit Dose	Student report of or observation of symptoms	School Year	School Year

Heath Care Provider Name: **Phone:** **FAX#:**

Health Care Provider Sign: **Date:**

Student Name:_____ **Birth Date:**_____
Address:_____
School Asthma Action Plan (page two)

Metered Dose Inhaler (MDI) Instructions

1. Store at room temperature.
2. Shake the MDI for 5 seconds before each use.
3. Prime the MDI before the first use or when not used every day. Follow the product's patient information sheet for MDI specific priming instructions. Priming usually involves pressing down on the medication canister to discard into the air one or more puff of medication. Discarding puffs makes sure the next puff inhaled contains the labeled amount of medication.
3. Keep track of metered inhalation puffs used. Subtract the number used from the number of metered inhalation puffs available listed on the label. The number of metered inhaled puffs available is listed on the medication canister or on the box. There are usually 200 puffs in an MDI.
4. Ask family for a new MDI when all labeled metered inhalation puffs are used.

MDI and Aerosol Solution Potential Adverse Reaction: Headache, shakiness, fast heart rate, nausea. Call parent with 1) student report of symptoms that interfere with schoolwork or activity 2) increase in side effects 3) frequent usage (2 times a day for 3 days).

We have instructed the patient and family in the proper use of the quick-relief medications. It is my professional opinion that the student:
____ should be allowed to carry and self administer the inhaled medication.

____ should **not** carry and self administer the inhaled medication. The medication should be stored and administered by designated school personnel.

_____ _____
Provider Signature Date

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Section II To Be Completed by Parent

I give permission for my child to receive medication at school in keeping with Section I above according to the school district policy and as instructed by the physician and agree to 1) Assume responsibility for safe delivery of the medication in its original container to the school, 2) Have a new form completed by the doctor if medication or dosage is changed, 3) Notify the school of changes in health care provider. I release from liability, and in addition agree to indemnify, all school employees, the Board of Education and Akron Children's Hospital School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct. I further agree to submit a revised statement signed by the physician who has prescribed the medication described in Section I in the event that I become aware that any of the above information has changed. I have read and understand the policy of the School Board for administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication at school-by-school personnel.

Parent/Guardian Signature: _____ Date: _____

Daytime Phone: _____
THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

Austintown Local Schools

SCHOOL ASTHMA RECORD

(To be Completed by Parent/Guardian)

Child's Name _____ Grade_____

Parent/Guardians(s) Name _____Cell_____

Home _____Work_____

Physician Treating Child's Asthma _____Phone_____

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1. When was your child diagnosed with asthma?_____
2. When was your child last seen by a doctor for their asthma?_____
3. Has your child ever been hospitalized for an asthma-related illness?_____

   If yes, when?_____
4. Please rate the severity of your child's asthma (circle one)

   NOT SEVERE 1 2 3 4 5 6 7 8 9 10 SEVERE
5. What triggers an asthma attack? (circle all that apply)

   Illness Emotions Medications Foods Weather Exercise

   Fatigue Odors Cigarette Smoke Other_____
6. Please describe your child's asthma attack (symptoms/duration)

_____

7. How do you treat an attack at home? (circle all that apply)

   Breathing Exercise Rest/Relaxation Drink Liquids

   Medications: Inhaler Nebulizer Treatment Oral Medication
8. Please list medications your child takes for asthma:

Name of Medication_____Frequency_____Time_____

Name of Medication_____Frequency_____Time_____

*****Please Return to the Clinic as soon as possible*****

Parent/Guardian Signature _____ Date _____