ASTHMA ACTION PLAN & AUTHORIZATION FOR MEDICATION

Attachment I
Regulation 757-5

TO BE COMPLETED BY PARENT:

Child's Name _____ Date of Birth _____ School _____ Grade _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Name of Physician/Nurse Practitioner/Physician Assistant _____ Office Phone ( )
Office Fax ( )

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

☐ Illness ☐ Cigarette or other smoke Food _____
☐ Emotions ☐ Exercise/physical activity 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 HEALTH CARE PROVIDER:

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

Symptoms OR	**Peak Flow Monitoring**	**Treatment**		
		Controllers & Relievers	**How much**	**When**
WELL • 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)	**GREEN ZONE** **Personal Best =** _____ _____ to _____	☐ Inhaled Corticosteroid		
		☐ Advair		
		☐-Symbicort		
		☐ Other		
		Leukotriene Modifier: Singulair		
		☐ Other		
		Relievers		
		☐ Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	☐ **2 puffs or 1 nebulizer treatment 5 min. before physical activity**
		☐ Other		
		Other		
SICK • 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	**YELLOW ZONE** _____ to _____	1. ☐ Continue daily controller medications 2. ☐ Give albuterol 2-6 puffs (1 min. between puffs) with spacer or 1 nebulizer treatment, wait 20 min. 3. ☐ If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 min. **Call parent and/or MD.** **<u>If no improvement, CALL 911</u>** **If child returns to Green Zone:** ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ No physical exercise ☐ Physical exercise as tolerated i.e. PE & recess at school		
EMERGENCY! • Reliever medications do not help • Very short of breath • Constant cough	**RED ZONE** <_____	☐**Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.** **<u>If there is no improvement, call parent and/or 911.</u>** ***<u>Call 911 immediately if:</u>*** • Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing		

PATIENT/STUDENT INSTRUCTIONS:

☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student <u>can carry and use his/her inhaler at school</u>
☐ Student is to notify his/her designated school health officials after using inhaler per school protocol
☐ Student needs supervision or assistance to use his/her inhaler ☐ Student shall **<u>NOT</u>** be able to carry his/her inhaler while at school

_____ _____ _____ ☐**Valid for current school year**

HEALTH CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER'S NAME** **DATE**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

_____ _____

PARENT SIGNATURE **DATE**

cc: principal____ office staff____ librarian____ cafeteria mgr.____ bus driver/transportation____ Coach/PE____ teachers____

CINCH
Virginia Asthma Coalition
revision 3/07

Attachment II
Regulation 757-5

RELEASE AND ACKNOWLEDGEMENT AGREEMENT BY PARENTS OF CIVIL IMMUNITY FOR SCHOOL BOARDS AND SCHOOL EMPLOYEES

I/WE UNDERSTAND THAT the Code of Virginia §8.01-226.5:1 grants civil immunity for school boards and school employees who, in good faith, without compensation, supervise the self-administration of inhaled asthma medications by a student. The Prince William County School Board and Prince William County school employees shall not be liable for any civil damages for acts or omissions resulting from supervising the self-administration of inhaled asthma medications by students.

IT IS FURTHER AGREED AND UNDERSTOOD that it is my/our responsibility to ensure that the medicine is properly labeled as to its nature and the means of administration. It is also my/our responsibility to ensure that the medicine is fresh and adequately stored, and that an adequate supply is available at school. If the dosage changes or the medication is to be stopped prior to the time noted in the prescription, it is my/our responsibility to communicate the change clearly, in writing, to school staff.

I/WE CONSENT to the above conditions and acknowledge that Prince William County Public Schools is acting as my/our agent in supervising self-administration of asthma medication by my/our child.

I/WE FURTHER STATE that this release and acknowledgement agreement has been carefully read and I/WE know of the contents thereof and have signed the same by my/our own free act.

CAUTION: READ BEFORE SIGNING BELOW

Medication requested to be self-administered:_____

_____ _____
Name of Parent/Guardian (Printed) Signature of Parent/Guardian

_____ _____
Child's Name (Printed) Date

(This agreement must be signed and returned to the building principal before medication can be administered.)