Clear Form

Virginia Asthma Action Plan

School: ***Effective Dates:***

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? ☐ YES ☐ NO	Contact by text? ☐ YES ☐ NO

Medical provider complete from here down

Asthma Triggers (Things that make your asthma

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Acid reflux ☐ Exercise ☐ Animals: _____ ☐ Pests (rodents, cockroaches) ☐ Other: ☐ Strong odors ☐ Mold/moisture ☐ Stress/Emotions

Season ☐ Fall ☐ Spring ☐ Winter ☐ Summer

Asthma Severity: ☐ Intermittent Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! — Take these CONTROL Medicines every day at home

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow:

Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. ☐ No control medicines

☐ Advair _____, ☐ Alvesco_____, ☐ Arnuity ____, ☐ Asmanex ____

☐ Breo _____, ☐ Budesonide ____, ☐ Dulera _____, ☐ Flovent ____, ☐ Pulmicort ____

☐ QVAR Redihaler ____, ☐ Symbicort _____, ☐ Other: _____

MDI: ____ puff (s) ____ times per day or **Nebulizer Treatment:** ____ times per day

Singulair/Montelukast take _____mg by mouth once daily

For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratopium *If asymptomatic not < than every 6 hours*

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: _____ to _____
(60% - 80% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer every _____ hours as needed

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent) 2.5mg/3m1

Nebulizer Treatment: one treatment every _____ Hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not work.

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow: < _____
(Less than 60% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer **every 15 minutes,** for **THREE treatments**

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

Nebulizer Treatment: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call 911 or go directly to the Emergency Department NOW!

I give permission for school personnel to follow this plan, administer medication and care for my child, and contact my provider 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. With HCP authorization & parent consent inhaler will be located in ☐ clinic or ☐ with student (self-carry)

PARENT/Guardian _____ Date_____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY

☐ **Student may carry and self-administer inhaler at school.**

☐ **Student needs supervision/assistance & should not carry the inhaler in school.**

MD/NP/PA SIGNATURE: _____ DATE _____

CC: ☐ **Principal** ☐ **Parent/guardian** ☐ **School Nurse or clinic** ☐ **Bus Driver** ☐ **Coach/PE** ☐ **Office Staff** ☐ **School Staff** ☐ **Cafeteria Mgr** **Transportation**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019

Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, **and District of Columbia Asthma Partnership**

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
INHALER AUTHORIZATION

Appendix F-3

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART 1 TO BE COMPLETED BY PARENT

I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Inhaler ☐ Renewal ☐ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date_____ Time_____

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances.

_____ Parent or Guardian Signature

_____ Daytime Telephone

_____ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)

DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS	MEDICATION AND ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL	INTERVAL FOR REPEATING DOSAGE:
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which inhalers are to be taken

Check ✓ the appropriate boxes:

☐ I believe that this student has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

☐ The student is to carry an inhaler during school and during sanctioned events with principal approval. (An additional inhaler, to be used as backup, WILL BE kept in the clinic or other approved school location.)

☐ It is not necessary for the student to carry his inhaler during school, the inhaler will be kept in the clinic or other approved school location.

☐ Asthma Action Plan is attached

_____ Licensed Health Care Provider (Print)

_____ Licensed Health Care Provider (Signature)

_____ Telephone or Fax

_____ Date

_____ Parent or Guardian

_____ Parent or Guardian Signature

_____ Telephone

_____ Date

_____ Student Signature (Required if student carries inhaler)

_____ Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

☐ Inhaler is appropriately labeled. _____ Date by which any unused inhaler is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

☐ I have reviewed the proper use of the inhaler with the student and agree/disagree that student should self carry in school.

_____ Signature

_____ Date

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide medications for student use**.
3. 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.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. 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 or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization 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.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. 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

10. 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.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. 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.