334 W. Central Ave., Zeeland, MI 49464, Phone: (616)772-2609, Fax: (616)772-2706

ASTHMA INDIVIDUALIZED HEALTHCARE PLAN

This order is valid for the school year (current) _________________, including the summer session.

This form must be completed fully in order for staff at Zeeland Christian School to administer your student's medication. A new Asthma Individualized Healthcare Plan must be completed any time that there is a change in orders (i.e., time, dosage, interventions, etc.).

- Prescription medication must be in a container labeled by the pharmacist or provider containing the student and medication names, medication dose and route, frequency of administration, the ordering healthcare provider's name, and a current date (unexpired). All information on the medication must match the information provided on this form.
- Non-prescription medications must be in the original container and unexpired, with the label intact.

Student Name: ____ Date of Birth: ___________________Grade: _______________

To be Completed by the Physician or Other Authorized Prescriber

The student is both capable and responsible to self-carry and self-administer this medication: ○ Yes ○ No

Please complete and sign attached Asthma Action Plan or submit a current plan already on file, with signature.

Any additional instructions: ____

____

Prescriber's Name/Title (Printed): _____________________________________

Address: ____

Phone: ___________________________ Fax: ____________________________

Prescriber's Signature: ____

Date: ____________________________

(Prescriber Address Stamp)

Parent/Guardian Authorization

I/We request that __________________________________ receive medication as prescribed by the above prescriber on the attached plan when necessary for school attendance. I/we request that the student receive the medication as administered by dedicated school personnel or be permitted to self-carry and self-administer the medication as authorized by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the above named student, including the administration of medication at school. I/We authorize the exchange of information and communication between the health care provider and the school. I agree to inform the school of any changes in medication and/or medical conditions. I realize I may withdraw my request/consent in writing at any time.
If my student will self-administer/self-carry this medication, I agree that in order for them to do so, I will:

- Confirm that my student is able to use correct medication administration technique.
- Instruct my student to never share their medication with another person
- Have my student carry their medication in its original, properly labeled prescriptive/over-the-counter container, along with a copy of this form
- Have my student carry, other than inhalers, only that day's supply of medication

Emergency Contacts for Allergic Reaction (Names and phone numbers): ____

____

Parent/Guardian Signature: ____ Date: _________________________________

School RN approval for self-carry/self-administration of medication:___________________________________Date:_________________

Asthma Action Plan for Home and School

Name ______________________________ **DOB** ____/____/______

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
Asthma Triggers (list) ______________________________
Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	____________	____________	____________	☐ Home ☐ School
	____________	____________	____________	☐ Home ☐ School

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine**(s)** ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed
Control Medicine**(s)** ☐ Continue Green Zone medicines
☐ Add ______________________ ☐ Change to ______________________

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, ______________________ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name ______________________ Date ________ Phone (_____) _____-________ Signature ______________________

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name ______________________ Date ________ Phone (_____) _____-________ Signature ______________________

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name ______________________ Date ________ Phone (_____) _____-________ Signature ______________________

Please send a signed copy back to the provider listed above.

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SELF-ADMINISTRATION OF INHALER STUDENT AGREEMENT

This order is valid for the school year (current) _________________, including the summer session.

Student Name: ____________________________________ Date of Birth: ___________________Grade: ____________________

To be Completed by the Student:

I agree to:

- Follow my prescribing healthcare provider's medication orders.
- Carry my medication in its original container properly labeled with my name, the medication name, the medication dose and frequency of administration, the ordering physician's name and a current date (unexpired) for all prescription medications, or an intact label and current date for all non-prescription medications, with my name written on the label.
- Carry a copy of my individualized healthcare plan with the medication.
- Carry, other than inhalers, only a day's supply of medication.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and all field trips.
- Notify the school nurse if:
    - My symptoms continue or get worse after taking my medication.
    - My symptoms recur within 2-3 hours after taking my medication.
    - I think I might be experiencing side effects from my medication.

I understand that permission for self-carry/self-administration of my medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student:____ Date:_______________________________________

For use by the Nurse:

☐ Student verbalizes correct dosage of medication

☐ Student able to verbalize asthma symptoms

☐ Student is carrying medication appropriately with a copy of the individualized healthcare plan

☐ Student demonstrates proper technique for medication administration.

For Inhaler:

1. Removes cap and shakes if applicable
2. Attaches spacer
3. Breaths out slowly
4. Presses Inhaler to release medication
5. Inhales slowly
6. Holds breath for 10 seconds
7. Repeats in 1 minute or as directed

☐ Student verbalizes safe use of inhaler (not sharing, when to come to the nurse's office)

School RN: ____ Date: ______________________________________