



School Year: \_\_\_\_\_

**MEDICAL FORM-ASTHMA HEALTH PLAN/CARE PLAN**

|                                                                                                                                                |            |          |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------|
| Name:                                                                                                                                          | Birthdate: | School:  |
| <input type="checkbox"/> History of anaphylaxis/severe reaction                                                                                | Grade:     | Teacher: |
| Transportation: <input type="checkbox"/> School Bus <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Walk/City Bus/Drive Self |            |          |

**HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE**

→ **Skill Level:** ☐ Independent (May carry & self-administer) ☐ Fully Dependent (Med in Health Room)  
☐ Working Toward Independence (May carry & administer WITH staff supervision)

**QUICK RELIEF MEDICATION:** ☐ Albuterol ☐ Other: \_\_\_\_\_ Use with: ☐ spacer ☐ mask

Controller Medication used at home: \_\_\_\_\_

Triggers: ☐ Weather ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Poor Air Quality ☐ \_\_\_\_\_

Weather restrictions: ☐ Stay indoors when temp below: \_\_\_\_\_ °F  
☐ Stay indoors during severe dust/wind ☐ Other: \_\_\_\_\_

|                 | IF YOU SEE THIS:                                                                                                                                                                                                                               | DO THIS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pretreat        | <ul style="list-style-type: none"> <li>No current symptoms</li> <li>Strenuous activity planned</li> </ul>                                                                                                                                      | Pre Treatment for strenuous activity. Choose one:<br><input type="checkbox"/> Not required <input type="checkbox"/> Student/Parent request <input type="checkbox"/> Routinely<br>Give QUICK RELIEF MED 10-15 minutes before activity<br><input type="checkbox"/> 2 puffs <input type="checkbox"/> other _____<br>Repeat in 4 hours, if needed for additional physical activity.<br><i>If student is currently experiencing symptoms, follow treatment for mild or severe symptoms and notify health room.</i>                                                                                     |
| Mild Symptoms   | <ul style="list-style-type: none"> <li>Trouble breathing</li> <li>Wheezing</li> <li>Frequent Cough</li> <li>Chest Tightness</li> <li>Not able to do activities</li> </ul>                                                                      | 1. Give QUICK RELIEF MED <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs<br>2. Stay with student and maintain sitting position.<br>3. REPEAT QUICK RELIEF MED if not improving in 15 minutes:<br><input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Other _____<br>4. May repeat every _____ hours as needed.<br>5. May return to normal activity when symptoms improve.<br>6. If symptoms do not improve but remain mild, notify parent.<br>7. If symptoms worsen, follow treatment for severe symptoms below and notify school nurse. |
| Severe Symptoms | <ul style="list-style-type: none"> <li>Coughs constantly</li> <li>Struggles to breathe</li> <li>Trouble Talking (can only speak 5 words)</li> <li>Skin of chest or neck pulls in with breathing</li> <li>Lips/fingernails gray/blue</li> </ul> | 1. Call 911 & follow building/bus emergency protocols.<br>2. REPEAT QUICK RELIEF MED if not improving:<br><input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Other _____<br>3. Can repeat every 5-15 minutes until EMS arrives.<br>4. Stay with student. Stay calm. Encourage slow, deep breathing.<br>5. Notify parents/guardians and school nurse.                                                                                                                                                                                                      |

|                                 |                            |
|---------------------------------|----------------------------|
| Health Care Provider signature: | HCP Printed Name:          |
| Date:                           | Phone #: _____ Fax#: _____ |

School Year: \_\_\_\_\_ - \_\_\_\_\_

**This section to be completed by the child's Parent/Guardian****EMERGENCY CONTACTS:**

| Mother/Guardian |       | Father/Guardian |       |
|-----------------|-------|-----------------|-------|
| Name:           |       | Name:           |       |
| Home Phone:     |       | Home Phone:     |       |
| Cell:           | Work: | Cell:           | Work: |

**ADDITIONAL EMERGENCY CONTACTS**

|    |               |        |
|----|---------------|--------|
| 1. | Relationship: | Phone: |
| 2. | Relationship: | Phone: |
| 3. | Relationship: | Phone: |

**FIELD TRIP PROCEDURES:**

- Emergency rescue medication and health care plan must accompany student during any off campus activity.
- If student does not have the rescue medication on the day of the trip, he/she cannot attend.
- If a staff member or parent/guardian carries the medication on the field trip, the student should remain with the person carrying the medication.
- Any staff member carrying or administering medication must be trained by school nurse.

**PARENT/GUARDIAN CONSENT TO HEALTH PLAN:**

- I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.
- I understand that if the provider has marked yes to weather concern accommodations, and my child is not marked independent, it is my responsibility to notify the school on a day that my child needs to stay inside due to weather.
- I understand that the school board or the school district's employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- Permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that the student is not safely and effectively self-administering the medication.
- I understand that if my child self-carries an inhaler/epipen, that it is recommended that I provide a back-up to be kept in the health room.
- I understand that if any changes are needed on the Health Plan, it is the parent's responsibility to contact the school nurse.
- I give health services staff permission to communicate with the LHCP's office about any medical treatment/medication orders that I provide to the school, in accordance with HIPPA/FERPA regulations. I understand that the school may share this care plan with emergency responders if student requires emergency services at school, in accordance with HIPPA/FERPA regulations.

Parent/Guardian Signature

Date

**STUDENT AGREEMENT FOR SELF-CARRY AND/OR SELF ADMINISTRATION:**

- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering, I will report to an adult at school if the nurse is not available or present.

Student Signature

Date

School Nurse Signature

Date

All school-aged students who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their health care professional and kept on file in the school office (RCW 28A.210.320.370). The form must also be signed by a parent/guardian. The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose). The provider's office is encouraged to fax the plan to the student's school nurse.