LINTON HALL SCHOOL

Linton Hall School

Asthma Action Plan

Dear Parent or Guardian,

Please provide the information requested below to help us care for your child's life-threatening asthma condition while at school.

Instructions for keeping lifesaving medication at Linton Hall School:

- The parent must bring the medication to the school office and give to a school representative.
- Unless an authorization to self-carry/self-administer has been submitted to LHS, medications are not to be left in the classroom, on the teacher's desk, in the student's lunch box, or in a backpack. *This applies to grades 5-8th only.*
- One "Medication Authorization for Prescription and Non-prescription Medications" (part 5 of this packet) form needs to be completed for each medication left at the school.
- The medication must be in the original container/packaging, including the pharmacist's/manufacturer's administration instructions.
- A completed Asthma Action Plan (attached) must be on file. This plan includes 6 parts:

Part 1 – Provides contact information for parents, emergency contacts and doctor. **To be completed by parent/guardian.**

Part 2 – Provides parent/guardian authorization to provide care. **To be completed by parent/guardian.**

Part 3 – Provides medical history as well as specific instructions/details for keeping the student safe while at school. **To be completed by parent and school representative.**

Part 4 – Provides medication authorization for **EACH** medication to be administered. This section will need to be completed for each medication being left at school. **To be completed by healthcare provider and parent/guardian.**

Part 5 – Provides authorization when a student is to self-carry and self-administer medication. **To be completed by healthcare provider, parent/guardian, and student.** *This applies to grades 5-8th only.*

Part 6 – Provides healthcare provider authorization to administer medication and action plan during an asthmatic reaction. **To be completed by healthcare provider.**

Please note: Asthma Action Plans must be submitted annually at the beginning of each school year and whenever modifications are made to this plan.

Place child's photo here

Asthma Action Plan

Student Name: _____ DOB: _____ Class: _____

Allergy to: _____

PART 1: To be completed by Parent/Guardian

1. Parent: _____ Phone Number: 1. _____ 2. _____

   Parent: _____ Phone Number: 1. _____ 2. _____

2. Emergency Contacts:
   Name/Relationship — Telephone Numbers

a. _____ 1. _____ 2. _____

b. _____ 1. _____ 2. _____

3. Dr. _____ Phone Number: _____

PART 2: To be completed by Parent/Guardian

Parent/guardian request for administration of medication

Schools must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian this written informed consent gives trained school staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented until all signatures have been obtained. Legally appropriate school health professional-medical prescriber communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student's academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

Student may not attend school until the written parental/guardian authorization has been signed and returned to the school. In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

Release of Liability / Hold Harmless

In consideration of Linton Hall School administering the above requested medication to my child _____, I hereby acknowledge that the school, its faculty and staff are not responsible for reactions to the medication, an improper dosage in the medication, etc., and will only be responsible for injuries relating to negligent physical administration of the medication.

I understand that the person administering this medication or treatment may or may not be trained or experienced in the administration of medications or treatments. I knowingly consent to these procedures and request that the medication/treatment be administered.

Print Parent's/Guardian's Name Date _____ _____

Parent's/Guardian's Signature Date _____ _____

PART 3: To be completed by Parent and School Representative

Medical History:

What are your child's typical asthma triggers?	
What age was your child when diagnosed?	
Has your child ever had a life-threatening reaction?	
Has your child ever received asthma medication?	
If yes, what are possible side effects we should watch for?	
What is your child's typical reaction like? Early warning signs/symptoms to watch for...	
Does your child have an allergy too? Have an EpiPen?	
What is the severity of the asthma?	
Is child on any other type of medications or supplements?	

Ways to keep student safe while at school:

For field trips, will you be transporting your child and staying to participate in the field trip?	
Are there classroom supplies that need to be eliminated from daily activity?	
Are there additional prevention steps that we need to take or other instructions/details you would like to share regarding your child's allergy that will help us to keep your child safe while at school?	

As a school, we will:

- Carry life-saving medication in locked bag at all times with your child.
- Notify you in advance of field trips, so you can address any risk of an asthmatic reaction.

Parent/Guardian' Signature _____ **Date** _____

School Representative's Signature _____ **Date** _____

PART 4: To be completed by Health Care Provider and Parent/Guardian

Medication Authorization for Prescription and Non-prescription Medications

Section A - Completed by the parent/guardian for ALL medication authorizations.
Section A & B - Completed for any long-term medication (*those lasting longer than 10 working days*) authorizations or for any medications required to be on hand daily for life threatening emergencies (*ie., epinephrine/ albuterol*). Section B is to be completed/signed by physician.

- The parent must bring the medication to the school office. Medications are not to be left in the classroom, on the teacher's desk, in the student's lunch box, or in a backpack.
- One form (front and back) needs to be completed for EACH medication left at the school.
- The medication must be in the original container/packaging, including the pharmacist/manufacturer's administration instructions. Children's anti-histamine must be in the unopened original container.
- **The medication must be accompanied by this completed and signed form.**

Section A: To be completed by parent/guardian (must be completed by the parent/guardian for ALL medication authorizations)

Medication authorization for: _____

(Child's name)

Linton Hall School has my permission to administer the following medication:

Medication name: _____

Dosage and times medication is to be administered: _____

Special instructions (if any): _____

This authorization is effective for the _____ school year or _____ to _____.

(Start date) (End date)

Parent's or Guardian's Signature: _____ **Date:** _____

Section B: The child's physician must sign this form for any long-term medication authorizations (*those lasting longer than 10 working days*) or for any medications required to be on hand daily for life threatening emergencies (*ie., epinephrine/ albuterol*))

I, _____ certify that it is medically necessary for the medication(s) listed above in

(Name of Physician)

Section A to be administered to: _____ for a duration that exceeds 10 work days.

(Child's name)

Special instructions (if any): _____

_____

Physician's Signature: _____ **Phone:** _____ **Date:** _____

PART 5: To be completed by Health Care Provider, Parent/Guardian and Student

PERMISSION FOR STUDENT TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE &/OR ALBUTEROL

Student Name: _____ DOB:_____

I, as the healthcare provider, certify that this child has a medical history of severe allergic reaction or asthma and has been trained in the use of the prescribed medication and is judged to be capable of carrying and self-administering epinephrine and/or albuterol. The nurse or designated school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medication with others and has agreed to refrain from this practice. I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication. Please indicate what authorization is being given:

Self-carry ☐
Self-administer ☐

Prescribed Medication/Dosage _____

Before allowing student to carry the prescribed medication, the healthcare provider will review proper use with the student. The physician must complete PART 5 of this packet "Medication Authorization for Prescription and Non-prescription Medications" for specific information concerning dosage and delivering the medication.

I DO _____ DO NOT _____believe that this student has received adequate education and has clear understanding on how and when to use the prescribed life-saving medication and is capable of safely carrying the medication on their person while in school.

Healthcare Provider Signature/Print Healthcare Provider Name/ Date _____.

_____ _____

I DO _____ DO NOT _____request that Linton Hall School permit the identified student to carry prescribed life-saving medication on his/her person in school or at school related events and be allowed to use it as soon as a severe allergic reaction or asthmatic attack begins. I agree to release, indemnify and hold harmless Linton Hall School, staff and agents from lawsuit, claim demand or action related to this medication use.

In order for all school staff to be aware of where to find the life-saving medication in the case of an emergency, the

*medication will be kept*_____.

Parent's/Guardian's Signature/Print Parent Name/Date _____

Student Signature /Print Student Name/Date _____

Principal or Designee Signature/Date_____

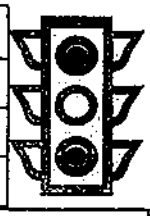
PART 6: To be completed by Health Care Provider, Parent/Guardian and School Representative

See attached Asthma Action Plan

Virginia Asthma Action Plan

School Division: _____

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email:



GREEN means Go!
Use CONTROL medicine daily
YELLOW means Caution!
Add RESCUE medicine
RED means DANGER!
Get help from a doctor now!

Asthma Severity

☐ **Intermittent** *or*

Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust
☐ Animals:_____ ☐ Strong odors ☐ Mold/moisture
☐ Pests (rodents, cockroaches) ☐ Stress/Emotions ☐Exercise
☐Gastroesophageal reflux ☐ Season (circle):Fall, Winter, Spring, Summer
☐ Other:_____

Last Flu Shot:	Pneumonia Shot:
/ /	/ /

Green Zone: Start [illegible]

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

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

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____, ____ puff (s) MDI with Spacer __ times a day
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist

☐ _____, ____ nebulizer treatment (s) __ times a day
Inhaled Corticosteroid

☐ _____, take ____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:

☐ _____, _____ puffs with spacer 15 minutes before exercise
Fast acting Inhaled β-agonist

For nasal/environmental allergy, ADD:

☐ _____, use _____ spray (s) per nostril _____ times a day
Nasal corticosteroid

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

You have **ANY** of these:

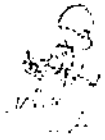
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

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

☐ _____, ____ puffs with spacer every ____ hours as needed
Inhaled b-agonist

☐ _____, ____ nebulizer treatment (s) every ____ hours as needed
Inhaled b-agonist

☐ Other _____



Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't 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 in this area:
_____ to _____
(Less than 60% of Personal Best)

☐ _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ _____, __ nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

Call your doctor while administering the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 for an ambulance,
or go directly to the Emergency Department!

SCHOOL MEDICATION CONSENT AND HEALTH CARE PROVIDER ORDER FOR CHILDREN/YOUTH

CHECK ALL THAT APPLY:

____ **Student has been instructed in the proper use of all of his/her asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER HIS or HER INHALER AT SCHOOL.**

____ **Student is to notify his/her designated school health officials after using inhaler at school.**

____ **Student needs supervision or assistance to use his/her inhaler.**

____ **Student should NOT carry his/her inhaler while at school.**

MD/NP/PA SIGNATURE: _____ **DATE**_____

REQUIRED SIGNATURES:

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.

PARENT/GUARDIAN _____ **Date** _____

SCHOOL NURSE/DESIGNEE _____ **Date** _____

OTHER _____ **Date** _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership