Jefferson Joint School District #251
Asthma Action Plan (AAP)

(For District Use)
Effective Date: _____

Student Name: _____ DOB: _____ School: _____

Age at diagnosis: _____ Grade: _____

Rescue medications will be: ❒ Stored in Office ❒ In Possession of Student – Location:_____

Action is necessary when the student has symptoms such as _____, _____, _____, or a peak flow reading of_____.

- **Steps to take during an asthma episode:**
  - ❒ Check peak flow. Personal best peak flow number: _____
  - ❒ Give Emergency Medications listed below. Student should respond to treatment in 15-20 minutes.
  - ❒ Re-check peak flow. Additional Instructions: _____
  - ❒ Contact parent/guardian if: _____

Call 911 if the student has any of the following symptoms:

- ✓ Coughs constantly
- ✓ No improvements 15-20 minutes after initial treatment with medication and a parent/guardian or emergency contact cannot be reached.
- ✓ Peak flow of: _____
- ✓ Difficulty breathing with:
  - Chest and neck pulled in with breathing.
  - Stooped body posture
  - Struggling or gasping for air
- ✓ Trouble walking or talking.
- ✓ Stops playing and can't start activity again.
- ✓ Lips or fingernails are blue or grey.

If This Happens, Get Emergency Help NOW!

Emergency Asthma Medications – Prescriber to Complete:

1. Medication Name: _____ **Dose/Route:** _____ **Frequency:** _____

Purpose of Medication: _____

Possible Side Effects: _____

Disposition of Student after Medication Administration: _____

2. Medication Name: _____ **Dose/Route:** _____ **Frequency:** _____

Purpose of Medication: _____

Possible Side Effects: _____

Disposition of Student after Medication Administration: _____

Daily Asthma Management Plan:

· Identify the triggers of an asthma episode (check all that apply)

❒ Exercise	❒ Pollens	❒ Change in temperature	❒ Food:_____
❒ Animals	❒ Respiratory infections	❒ Carpets in room	❒ Other: _____
❒ Molds	❒ Strong odors or fumes	❒ Chalk dust/dust	❒ Other: _____

• Control of the School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

_____

_____

Special Instructions:

Please list any special instructions: _____

_____

_____

_____

• **Field Trips:** Asthma Action Plan, Medication, Peak Flow Testing Supplies, and Asthma trained personnel must accompany student on all field trips.

_____

_____

_____

_____

_____

• Comments

***The Asthma Action Plan with included Medication Prescription Information and Licensed Independent Provider and Parent/Guardian Signatures requires review or renewal annually.

PARENT/GUARDIAN TO SIGN – Authorization for Exchange of Confidential Student Information

I authorize my child's **Health Care Provider** (name) _____to exchange confidential health information with the District Nurse for the completion of this plan of care and to exchange health information and records for not more than 12 months after signature date.

Parent/Guardian Signature _____ **Date** _____

By signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding my child. The parties may also accept a photocopy of this release form and give it the same full force and effect as the original. I further understand that I may revoke this authorization in writing at any time by providing a copy of my revocation to the parties named above. The information used or disclosed under this release might be disclosed by the school district as an educational record, pursuant to FERPA and might no longer be protected by HIPAA.

TO BE COMPLETED BY PARENT/GUARDIAN:

As Parent/Guardian of the named student:

* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.
* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.
* I understand that a school team, including the parent/guardian, may make decisions about implementation and assistance in the school based on consideration of the above recommendation, available resources, and the student's level of self-management.
* I agree to indemnify, defend, and hold the School District harmless from any and all claims, actions, cost, expenses, damages, and liabilities, including attorney's fees, arising out of, connected with, or resulting from the administration of medication.
* I agree that the School District, Board of Education, Board of Education Employees and its Agents shall incur no liability as a result of any injury arising out of or connected with the administration of medication.
* I agree I will not institute either on our own behalf or behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with administration of medication.
* I understand this agreement must be signed and in full effect prior to the administration of medication.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand School Authorities will notify Parent/Guardian at the end of the school year to pick up medication. Medication which is not repossessed by the Parent/Guardian within a seven-day period of notification by school authorities will be destroyed by the School Nurse in the presence of a witness.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order.

_____ ( )_____

Parent/Guardian Name (please print) Best Contact Phone Number

_____ _____

Parent/Guardian Signature **Date**

TO BE COMPLETED BY PHYSICIAN:

Student Independence Level

As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of Asthma; and per my assessment:

❒ This student has been instructed in the proper way to administer his/her asthma medications and is capable of self-carrying and self-administering his/her own asthma medications.

❒ This student requires a trained adult to administer asthma rescue medications.

_____ ( )_____

Licensed Independent Provider (LIP) Name (please print) Phone Number

_____ _____

LIP Signature **Date**