Date Plan was Developed:_

RIVERSIDE SCHOOL DISTRICT

School Nurse 220-9143

ASTHMA
LICENSED HEALTH PROFESSIONAL (LHP) ORDERS / CARE PLAN

STUDENT'S NAME		
School	Grade	Birthdate
Doctor:	Phone #:	Fax:
Transportation ☐ Walk ☐ Car ☐ Bus #		
Physical Education – Days and Time or Period:		
Medications taken at home:		

LICENSED HEALTH PROFESSIONAL - DAILY ASTHMA MANAGEMENT PLAN
(*Must be completed by licensed health professional*)

Identify asthma triggers (*Check each that applies to this student*)

☐ Exercise ☐ Pollens Personal best peak flow _____ ☐ Molds ☐ Respiratory infections
☐ Change in temperature/Season ☐ Other ______________________________

*****Warning signs of an Asthma Episode:**______________________________

ROUTINE medication to be given at school. If more than one medication is to be given, list in order to be given.

Medication	Amount	When to use
1.		
2.		

SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached, or if condition worsens during this period
- Peak flow less than _____
- Difficulty walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue
- Difficulty breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe

CALL 911

Inhaler kept in:
☐ Office
☐ Backpack
☐ On Person
☐ Coach
☐ Other____________

EMERGENCY ASTHMA MEDICATIONS

Medication	Amount	When to use	Route
1.			
Side Effects:			

Time Interval for Repeating Dosage:

- If symptoms not relieved after initial dose
- If symptoms reoccur before next dose is due

It is my professional opinion that this student (circle one) **SHOULD / SHOULD NOT** carry and use his/her rescue medication/s/ by himself/herself at school. I have instructed this student in the proper way to use these medications.

********He/she has successfully demonstrated the ability to self-administer*. ☐ **YES** ☐ **NO** ☐ **Unable---Why**__________

LHP Signature	Date	Telephone Fax Number
LHP Printed Name	Start Date:	End Date:

PARENT/GUARDIAN SECTION

***After completing section below, see permission to carry inhaler form, if your child has their HCP's permission to carry an inhaler.*

Mother:	Father:	Emergency Contact with Phone #	
Home			
Work			
Cell			

Parent's signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician if necessary.

Parent/Guardian Signature Required Date

NURSE REVIEWED:______________________________

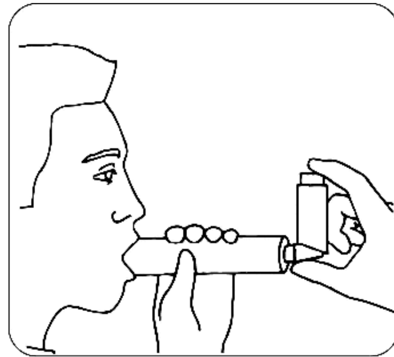
Steps for using a Metered Dose Inhaler Correctly:

1. Places canister in the mouthpiece and removes the cap

2. Shakes the metered dose inhaler (MDI) unit rapidly for 3 seconds

3. Tilts head back slightly and breathes out.

4. Positions the inhaler in one of the following ways.



5. Presses down on the inhaler to release medication as they start to breathe in slowly.

6. Breathes in slowly (3-5 seconds).

7. Holds breathe for 10 seconds to allow medication to reach deeply into lungs.

8. Repeats puffs as directed. Waits 1 minute between puffs to permit the second puff to penetrate the lungs better.

Parent/Student Agreement for Permission to Carry an Inhaler

LHP must also sign that student should carry an inhaler at school on the LHP Orders/Care Plan for Asthma)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- 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.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new HCP Order/Care Plan for Asthma and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

____ ________________________

Parent/Guardian's Signature Required Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse.
- 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 the school nurse or another appropriate adult if the nurse is not available or present.

____

Student's Signature Required Date

Riverside School District

NURSING SERVICES
4120 E. NEWPORT HWY CHATTAROY, WA 99003 • Telephone (509) 464-8350 • Fax (509) 464-8365

CHECKLIST FOR DEMONSTRATING PROPER USE OF INHALERS

Student ___________________Birthdate ________ School _______________ Grade___

Medication ____________________Dose ___________ Frequency _____________

Yes____No____Instructed____Family brought in medication with Medication Request Form completed that student may carry and self administer medication. Inhaler is labeled with student's name.

Yes____No____Instructed____Student describes prescribed timing for medication to school nurse.

Yes____No____Instructed____Student demonstrates correct use and or administration of medication to school nurse (according to the steps on the reverse side).

Yes____No____Instructed____Student agrees not to share medication with others.

Yes____No____Instructed____Student agrees to keep medication in the following location _____________________.

Yes ___ No____Instructed____Student agrees to seek help if symptoms are not relieved after taking medication as prescribed.

Yes____No_____Instructed____Student knows not to go anywhere alone when having an asthma attack.

Additional comments:

_________________________________ ____________________
School Nurse Date