Asthma Specific

**KENT SCHOOL DISTRICT**
**Licensed Health Care Provider (LHCP) Medication Order and Action Plan**

| | | | | | |
|---|---|---|---|---|---|
| **Student Name:** | | **Birthdate:** | | **Grade** | |
| **School:** | | **Student #:** | | **Bus Route:** | |
| **Emergency Contact Numbers** | **Home:** | **Cell:** | | | |
| | **Work:** | **Email:** | | | |
| **Inhaler kept in:** | ☐ Health room ☐ Backpack ☐ Other: | | | | |

## This portion to be completed by Licensed Health Care Provider (LHCP)

**Diagnosis**: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Life-threatening

| | Name of Medication | Dosage | Method of Administration | Time of Day To Be Taken |
|---|---|---|---|---|
| **1** | | | | |
| **2** | | | | |

**Is Epinephrine to be used for unresolved or severe symptoms (see # 5 under "Steps to Take During an Asthma Attack)? School Nurse will be consulted.** ☐ Yes – please indicate dosing/strength below ☐ No

☐ Epinephrine 0.3 mg ☐ Epinephrine Junior 0.15 mg (66 pounds or less)

☐ Student is capable of self-administering medication.

☐ Student has permission to carry and self-administer the medication ordered above.

☐ Student can reliably report asthma symptoms.

☐ Student to use peak-flow meter per attached directions.

Possible side effects of medication(s): _____

**Steps to Take During an Asthma Attack (Action Plan):**

Common symptoms of asthma (note: any symptoms can potentially progress to a life-threatening situation):

**Persistent cough, Wheezing while breathing in or out, Shortness of breath, Tightness in chest**

1. Send student to the health room with escort. If student carries medication, send to health room if student's condition is not improved after using inhaler.
2. Health Room staff to give medications as directed above if not already done.
3. Have student return to classroom if symptoms improve.
4. Contact parent if no improvement after using medication or if no improvement and medication not available.
5. **Call 911 if Severe Symptoms which may include: Rapid Labored breathing, Sweaty, clammy skin, Nasal flaring, Becoming anxious, Unable to talk in full sentences, "Pulling in" of neck and chest with breathing, Other: _____**

## Licensed Health Care Provider AND parent/guardian to sign below. Parent/Guardian to complete back.

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above. There exists **a valid health reason, which makes administration of the medication advisable during school hours** or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel. I have read the medication policy and procedures outlined on the back of this form. Also, the School Nurse may contact the prescriber regarding questions related to this medication/special instruction order.

| | | |
|---|---|---|
| Date: | | Parent/Legal Guardian's signature: |
| Date: | | Licensed Health Care Provider signature: |
| Phone: | | Name (printed or stamped): |
| Fax: | | Address: |

**Duration of order:** ☐ current school year ending August 30th ☐ Other: _____ **OVER→**

**ASTHMA INFORMATION (to be completed by parent/guardian)**

My child ☐ will ☐ will not (please mark appropriate spot with X) participate in **KSD sponsored** before or after school sports/activities during the school year. If this changes it is my responsibility as the parent/guardian to contact the health room. List sports/activities: _____

1. How long has your child had asthma? _____ years _____ months
2. How many days would you estimate he/she missed school **last year** due to asthma: _____
3. How many times in the past year has your child been:
   A ) Hospitalized overnight or longer for asthma? (check one) ☐none ☐one ☐two-four ☐more than four
   B ) Treated in an emergency room? (check one) ☐none ☐one ☐two-four ☐more than four
   C ) Treated in a Doctor's office for non-routine asthma? (check one) ☐ none ☐one ☐two-four ☐more than four
4. **Asthma Triggers:** (Check each that applies to the student.)
   ☐Exercise ☐Food ☐Pollens ☐Stress
   ☐Respiratory Infections ☐Strong Odors of Fumes ☐Molds ☐Cigarette smoke
   ☐Change in Temperature ☐Animals ☐Carpets in Room ☐Other_____
5. What are your child's early warning signs of an asthma episode? (check all that apply)
   ☐cough ☐cold symptoms ☐drop in peak flow
   ☐wheezing ☐decreased exercise ☐other _____
6. If your child's asthma is monitored with a peak flow meter, write in his/her best peak flow rate: _____
7. List all medications your child takes for asthma. Please include routine and non-routine (as needed) medicines. Indicate if using metered dose inhaler (puffer), spacer/chamber, nebulizer, or pills.

| **Medication taken routinely** | **Amount** | **How Taken** | **Time Given** |
|---|---|---|---|
| | | | |
| | | | |
| **Non-routine (as needed Medication** | **Amount** | **How Taken** | **Time Given** |
| | | | |
| | | | |

8. If your child has a severe asthma episode and emergency services (e.g. 911) are called, what is your choice of hospital for treatment? _____ *Note: Hospital choice may not be an option at time of emergency.*

**KENT SCHOOL DISTRICT - MEDICATION PROCEDURE**

Washington State Nurse Practice Act (WAC 246-839-700) will be designated to provide care.

**Washington State law permits school staff to administer medication only in limited situations.** When possible, the parents and physician are urged to design a schedule for **giving medication outside school hours.** Medication is defined to mean all drugs, whether prescription or "over the counter".

**Prior to administration of any medication, the following requirements must be met:**

1. **Parent/legal guardian note** must be on file giving name of medication, dosage, time, dates to be given, student name.
2. **Licensed Health Care Provider's (LHCP) note** for each medication must be on file that there exists a valid health reason which makes administration of such medication advisable during school hours or when a student is under the supervision of school officials. The LHCP's note must also indicate name of medication, dosage, time, and dates to be given, possible side effects, LHCP's signature. This request is valid for a period not to exceed current school year (HS37-02).
3. All medication must be in the **originally labeled container** and be labeled with student's name. This pertains to oral medications (pills, liquids, inhalers).
4. A responsible adult delivers the medication to the school. All medications will be counted upon receipt and recorded on back of medication recording form. **If this is a new medication for the student, the first dose must be given at home prior to bringing the medication to school.**
5. There are situations where the parent or physician or principal **and** school nurse believe it is in the best interest of the student that he or she carry and self-administer the medication. In these cases the student shall be permitted to carry and self-administer the medication. Only one day's dosage (in originally labeled container) shall be carried by the student. The original LHCP and parent authorization will be kept in the health room. The parent recognizes and acknowledges the liability for lost, stolen, and/or shared medication.

| Parent/Guardian Signature: | Title/Relationship: |
|---|---|
| School Nurse Signature: | |

6. If requirements 1, 2, and 3 are not met and parents want the child to have the medication, the parent may come to school and administer the medication.
7. In most cases, it will be the child's responsibility to come to the office at the appropriate time for medication. The parent may put a note in the lunch box to remind the child to take the medication. On scheduled early dismissal days, when lunch is served, "lunch time" or "noon" medications will be dispensed unless requested otherwise by Parent.
8. The nurse must be consulted prior to bringing any injectable medications to school and additional forms must be completed: HS-037-02, Request for Special Nursing Care/Medical Treatment Procedures. The physician's instructions should outline symptoms and when to give the injection.