

## ASTHMA

### LICENSED HEALTH PROFESSIONAL (LHP) ORDERS / CARE PLAN

STUDENT'S NAME			
School	Grade	Birthdate	
Doctor:	Phone #:	Fax:	Preferred Hospital:
Transportation <input type="checkbox"/> Walk <input type="checkbox"/> Car <input type="checkbox"/> Bus #			
Physical Education – Days and Time or Period:			
Medications taken at home:			
Brief History:			

### 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. (ie, Albuterol, 2 puffs, prior to exercise)	
Medication	Amount	When to use
1.		
2.		

EMERGENCY ASTHMA MEDICATIONS			
Medication	Amount	When to use	Route
1.			
<b>Side Effects:</b>			
<b>Time Interval for Repeating Dosage:</b>			
• If symptoms <u>not relieved</u> after initial dose (do this):			
• If symptoms reoccur <u>before</u> next dose is due (do this):			

### 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 \_\_\_\_\_

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:

School Nurse Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT/GUARDIAN SECTION**

**EMERGENCY CONTACTS**

**Mother/Guardian**

Name
Home Phone
Work Phone
Other

**Father/Guardian**

Name
Home Phone
Work Phone
Other

**ADDITIONAL EMERGENCY CONTACTS**

1.	Relationship:	Phone:
2.	Relationship:	Phone:

**Parent/Student Agreement for Permission to Carry an Inhaler & update ECP**

**Licensed Health Care Professional must also sign that student should carry an inhaler at school on the LHP Orders/Care Plan for Asthma (on front)**

**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/school nurse if it is determined that your child is not safely and effectively self-administering the medication.
- A new LHP Order/Emergency Care Plan for Asthma and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.
- I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other school programs of their child's health condition. Such as sports/field trips, etc.
- *My signature below shows I have reviewed and agree with this Emergency Care Plan and give permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact the physician if necessary.*

Parent/Guardian 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

**SCHOOL NURSE SECTION**

**CHECKLIST FOR DEMONSTRATING PROPER USE OF INHALERS**

Yes \_\_\_ No \_\_\_ Instructed \_\_\_ Family brought in medication with Emergency Care Plan/Medication 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.

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