

Pinckneyville Community High School District 101
Health Service Asthma Action Plan

Student Information (To be completed by parent and reviewed annually)

Name of Student: _____ D.O.B.: _____ Class _____

Sports/ Extracurricular _____

ID PHOTO

Emergency Information

Parent(s)/guardian(s) names: _____

Phone# Home _____ Cell _____ Work _____

Physician Treating Student for Asthma

Name/ town _____ Ph _____

Asthma Emergency Action Plan

Asthma Triggers: Please circle Exercise Pollens Burning leaves Mold Change in temperature

Respiratory Infection Food _____ Animals _____ Strong odors or fumes _____

Other _____

List any control measures used to prevent an asthma episode – (ie diet or environmental)

Personal best peak flow _____

Asthma Controller Medication(s) taken outside of school

Name of medication	Dosage	Time

If this student does have a problem with endurance sports, please permit him/her to take the following medication: _____ 10-20 minutes before participating.

Each asthmatic child has a different limit of tolerance to exercise. Please permit the student to set his/ her own pace on a daily basis. In particular, asthmatics have difficulty “ running laps” and playing competitive soccer and basketball; please do not “force the child”, but let the student participate at his/her own level. ☐ Warm-up exercises are often useful in warding off wheezing episodes.

Quick-Relief Medications to Be Given at School

(Physician Authorization for Medication form updated yearly)

Name of medication	Dosage	

See reverse for more instructions

Asthma Episode - Symptoms

If the student exhibits any of the following signs:

- Difficulty breathing, walking, or talking
- Wheezing or shortness of breath ☐ Cough
- Student reports "needing inhaler"
- Other: _____

Asthma Episode -Action ☐ Give Quick-Relief medication as noted on reverse side

***If no Quick-Relief meds go to SEVERE Asthma Episode- Action**

- **Summon or notify school nurse or athletic trainer of student's condition regardless of severity.**
- Stay with the student and observe for improvement.
 - *Stay calm, speak softly, encourage student to take slow, deep breaths.
 - *Seat student comfortably, indoors if possible, loosen clothing, if needed.
- Do not permit student to lie down or fall asleep.
- Monitor student for 15-20 minutes then allow student to return to class and activities.
- Student should respond to treatment in 10 minutes. If no improvement go to **SEVERE Asthma- Action**

Severe Asthma Episode- Symptoms

If student has any one or more of the following severe asthma episode symptoms

- Hard time breathing with:
 - *Coughs constantly
 - *Chest and neck pulled in with breathing, skin retracting/sucking over child's neck
 - *Nasal Flaring
 - *Stooped body posture
 - *Struggling or gasping
 - *Cannot walk or speak
- Blue or gray discoloration of the lips or fingernails

Severe Asthma Episode- Action

GET EMERGENCY HELP NOW!! Do the following in this order

- **Call 911 Immediately**
- **Call School Nurse, if not already present**
- **Call Parent/Guardian**
- If medication is available, repeat Quick-Relief medication, 2-4 puffs every 10-20 minutes for up to one hour or use nebulizer once, until help arrives or breathing improves.

Review Asthma Plan and sign off policy statement yearly

Attach a completed Physician Authorization for Medication

Self-Administration of Medication
Policy Statement
Pinckneyville Community High School

Dear Parent or Guardian,

The Pinckneyville Community High School has received your request for self-administration of _____, for your child _____.

State law requires that we inform the parents or guardians of the student, in writing, that the school district and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

Before we can allow your child, _____, to self-administer the medication we must ask you to sign and return a copy of this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student with asthma, potential for a severe allergic reaction or diabetes may possess and use his / her medication while in school, at school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his / her medication.

I _____, acknowledge that Pinckneyville Community High School, District #101 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. I indemnify and hold harmless the school district and its employees and agents any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signed _____ Date _____
Parent or Guardian

School Nurse Signature _____ Date _____

Parent/Student Agreement to Carry Medications
Pinckneyville Community High School #101

I give permission for my child, _____, to carry the medications described below. * I understand that he / she must follow the rules listed below. I will notify the school of changes in medication if my child's condition changes.

* Inhalers, epinephrine-pens, insulin and glucose tablets, are the only medication that may be carried by a student.

Name of Medication	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____

Parent / Guardian Signature _____

Date _____

I, _____ a student at Pinckneyville Community High School District #101, agree to the following:

1. I have demonstrated the correct use of inhaler, epinephrine injector or insulin to the health care provider and school health personnel.
2. I agree to never share the medication with another person.
3. I agree to notify the nurse, teacher or other responsible adult who will seek further medical intervention as outlined in my Individual Health Action Plan when:
 - there is not marked improvement after using inhaler (2 puffs)
 - an allergic reaction is suspected
 - epinephrine is used
 - abnormal blood sugar is suspected

Student Signature _____ Date _____

**School Medication Authorization Form
Physician Authorization
Pinckneyville Community High School District #101**

Student's Name Birth Date School/District Date

Please complete the designated areas marked below and return to the school nurse. This information is confidential between the physician, parent, teacher, and school nurse. Thank you for your cooperation.

Physician Authorization for Medication at School:

I am requesting that the above named student take the following medication during school hours.

Name of Medication/Health Care treatment Dosage/Route

Frequency/Time to be administered

Diagnosis requiring Medication

Side effects/Reactions to these medications to which the nurse and/or teacher should be alert.

Asthma Plan: Personal Best Peak Flow number: _____

If this student does have problem with "endurance" sports, please permit him/her to take the following medication: _____ *before participating to prevent symptoms.*

In case of breathing difficulty, acute asthma attack, have the child take prescribed medication:

Other instructions: _____

* If the treatment is ineffective or symptoms are severe, transport to the ER immediately.

Authorization for Self-administered medication (asthma inhalers, Epi-pen, glucose)

I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he /she should be allowed to carry and use that medication by him/ herself.

It is my professional opinion that _____ should not carry self-administered medication by him/herself.

List other medications the child is receiving _____

Start Date/Stop Date

Re-evaluation Date

Physician Signature

Date signed

Physician's Emergency phone number

Physician's address