Guthrie Public School
ASTHMA ACTION PLAN

School: **Teacher:** **Grade:**

Student Name	**Date of Birth**

Parent/Guardian	**Parent Guardian Phone**	**Parent/Guardian Email**

Emergency Contact	**Emergency Contact Phone**

Asthma Triggers (Things that make your asthma worse)

☐ Colds	☐ Dust	☐ Animals:________________	☐ Strong odors	Season	
☐ Smoke	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/Moisture	☐ Fall	☐ Spring
☐ Pollen	☐ Exercise	☐ Other:________________	☐ Stress/Emotions	☐ Winter	☐ Summer

Asthma Severity: ☐ **Intermittent or** ☐ **Persistent:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep at night

Take these CONTROL (PREVENTION) Medicines at Home Every Day

☐ No control medicines required

☐ Advair ☐ Flovent ☐ Pulmicort ☐ Symbicort ☐ Singulair (Montlukast)

☐ Other: ______________________________

For asthma with exercise, ADD: ☐ Albuterol ☐ Other______________________

MDI _____ puffs _____ minutes before exercise at school ☐ **PE class** ☐ **Recess** ☐ **Sports**

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs every _____ hours as needed

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) ______ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment every _____ hours as needed

☐ Other: ______________________________

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs **every 15 minutes**, for **THREE** treatments

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) ______ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other: ______________________________

CALL 911

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I understand this Asthma Action Plan must match the Medication Authorization form completed by my Healthcare Provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

Parent/Guardian ______________________________ Date____________

School Nurse______________________________ Date____________

☐ Teachers ☐ Coach/PE ☐ Office Staff ☐ Bus Driver/Transportation

Guthrie Public Schools

Parental Authorization to Administer Medicine or Assist with Application of Sunscreen

TO: ______________________________ ______________________________

(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of ______________________, a minor student attending this school.

☐ This student requires medication (not including sunscreen) at intervals during the school day. I hereby give my consent and authorize the school nurse, the principal, or _____________ (an employee of the School District designated by the school nurse, the principal, and me) to administer:

☐ (name of drug) ____________________, a non-prescription medication which I am hereby supplying you, in accordance with my written instructions or the written instructions of a physician which are attached hereto.

☐ (name of drug) ____________________, a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

☐ (name of drug) ____________________, a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

☐ I hereby give my consent and authorize my child to self-medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written authorization. I hereby give my consent and authorize the school nurse, the principal, or _______________ (an employee of the School District designated by the school nurse, the principal, and me) to assist the student in applying sunscreen:

☐ sunscreen, which I am hereby supplying you, in accordance with the label directions.

☐ sunscreen, which I am hereby supplying you, in accordance with written instructions of the student's physician which I have attached.

I understand that under state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

______________________________ ______________________________

Date Signature

______________________________ ______________________________

Address Parent with legal custody/guardian

Guthrie Public Schools
MEDICATION AUTHORIZATION

Student: ______________________ **Birthdate:** __________ **Grade:** ____ **School:** ______________

Parent/Guardian: ______________________ **Phone:** ______________________ **Date:** ___________

PRESCRIPTIONS TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- Reason for medication ______________________
- Name of medication ______________________
- Dosage ______________________
- Time and Route to be administered ______________________
- Duration (week, month, indefinite, etc.) ______________________
- Possible side effects ______________________

______________________ ______________________ ______________________
Physician/Licensed Prescriber's Signature Office Phone Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby request and give my permission for the above-named school to administer the medication authorized on this form to my child. I understand that I am responsible for maintaining the supply and picking up any remaining medication at the end of the school year; medication will not be sent home with students. Medication remaining after the school year has ended will be discarded utilizing proper procedure. I give my permission to the school nurse/designated employee to consult with the prescriber regarding this prescription.

______________________ ______________________
Parent/Guardian Signature Date

COMPLETE ONLY FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, ANAPHYLAXIS MEDICATION, OR REPLACEMENT PANCREATIC ENZYMES

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- This student has been instructed in the proper use of his/her medication. It is my professional opinion that this child is both capable and responsible of self-administering this medication and shall be allowed to carry this medication on his/her person. Yes ☐ No ☐

______________________ ______________________
Physician/Licensed Prescriber's Signature Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby give my consent and authorize my child to self-administer and/or self-carry his/her medication at school.
I will provide an emergency supply of this medication to be administered by school personnel, as required by State law.

______________________ ______________________
Parent/Guardian Signature Date

I will not knowingly share my medication with another student.

______________________ ______________________
Student Signature Date

It is Guthrie Public Schools policy that medication and sunscreen will only be administered by school staff with written authorization of the child's legal custodian and/or written instructions from the child's physician. Medication must be in the original container with proper labeling: child's name; medication name, strength, and expiration date; dosage and instructions for administration; name of licensed prescriber/physician; pharmacy name, address, and phone number. Authorization forms must be completed annually for each medication, and for any changes to dose/administration time. School staff will not administer medication or sunscreen that is not in the original container, improperly labeled, unauthorized, or expired. Medication must be brought to school by a parent/legal guardian.

Receiving Employee: ______________________ Date: ______________________