Lovejoy Independent School District School Year_____
School Asthma Action Plan Bus #_____

Place Child's

*Name*_____ *DOB*_____ *ID#*_____ *Picture Here*

Grade _____ **Teacher/Section** _____

Emergency Contacts:

Name	Daytime Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

DAILY ASTHMA TREATMENT AND EMERGENCY PLAN

Medical Equipment:

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer supplies, oxygen, etc.). *Parent will provide equipment needed:* _____

_____

Green Zone - Peak Flows _____to_____ *No symptoms (peak flow between 80-100% of personal best)*:

☐ No control medicines required OR

Oral control medication _____ taken _____ times a day.

_____ puff(s) _____ MDI _____ times a day.

_____ nebulizer treatment(s) _____ times a day.

For asthma with exercise: _____ puff(s) _____ 15 minutes before exercise.

Yellow Zone – Peak Flows _____to_____ *Tight chest, cough or mild wheeze, signs of upper respiratory illness, unable to exercise (peak flow between 50-80% of personal best)*:

_____ puff(s) _____ MDI every _____ hours as needed **OR**

_____ nebulizer treatment(s) every _____ hours as needed

Other

_____

Red Zone – Peak Flows below _____ *(peak flow less than 50% of personal best)*: **EMERGENCY ACTION IS NECESSARY WHEN THIS STUDENT HAS SYMPTOMS SUCH AS:**

- **Can't talk, eat or walk well**
- **Medicine is not helping**
- **Chest/neck retractions**
- **Breathing hard & fast**
- **Blue lips and/or fingernails**
- **PO_2 less than _____%**

_____ puffs _____ MDI every _____ minutes for THREE treatments OR

_____ nebulizer treatment every _____ minutes for THREE treatments.

☐ Contact parent ☐ Call 911_____

Other _____

Comments and/or special instructions: _____

Physician Designation of Rescue Drug

I have prescribed asthma medication(s) for the student named here for use on an as needed basis. In recognition of the possible need to promptly administer this drug while in attendance at Lovejoy Independent School District, when a trained medical professional may not be available, I acknowledge that circumstances may arise in which an unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to emergency medical personnel, a physician and / or a registered nurse, may need to administer the asthma medication(s) to the named student.

☐ **I agree** / ☐ **I do not agree** (check one) **Physician Initials**_______ **Parent Initials** ____________

Physician's Consent for Self Administration of Asthma Medication

I have instructed the student in the proper way to use his/her asthma medications. It is my professional opinion that this student ☐**should** / ☐**should not** (check one) be allowed to carry and self-administer his/her medications while on school property or at school-related events. **Physician's initials** ________

Physician's Name ____ **Phone**____________________

Physician's Signature____ **Date**_____________________

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Background Information

Asthma Severity:
☐ Intermittent ***or***
Persistent: ☐Mild ☐Moderate ☐Severe
Asthma Control:
☐Well-controlled ☐Needs better control

Asthma Triggers: ☐Colds ☐Pollen ☐Dust ☐Animals _____________
☐Smoke ☐Pests (rodents, cockroaches) ☐Stress
☐ Exercise ☐Gastroesophageal reflux ☐Strong Odors
☐Season _______________ ☐Other_______________

Has the student ever experienced a severe asthma episode in the past that required emergency room care or hospitalization? What care was needed at that time?____

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Parent/Guardian Consent for Self Administration of Asthma Medication

I ☐**do** / ☐**do not** (check one) agree with his/her physician to allow my child to carry and self-administer his/her asthma medications. If my child caries his/her own asthma medication, I realize that the school clinic will not have his/her personal asthma medication(s) unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s). However, I acknowledge that the school is relying on my representation that my child is adequately trained to identify symptoms and self-administer his/her asthma medication(s). **Parent initials** ________

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Asthma Medication

I ☐**do** / ☐**do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse, to administer asthma medication(s) to my child while in attendance at Lovejoy ISD or Lovejoy ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** _____

Parent/Guardian Consent to Share Information and Picture

I ☐**do** / ☐ **do not** (check one) authorize Lovejoy ISD to display a picture of my child and identify that this is a person with asthma. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other LISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Asthma Medication to the Student, the Student's self-administration of Asthma Medication and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of Asthma Medication to the student and/or Student's self-administration of Asthma Medication, or the disclosure of Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s), negligently failed to recognize

symptoms requiring the use of Asthma Medication, misconstrued symptoms which it believed necessitated the use of Asthma Medication, negligently administered or failed to administer Asthma Medication(s), or "over-disclosed" my child's health information.

Parent/Guardian Name _____ **Phone** _____

Parent/Guardian Signature _____**Date** _____