Asthma Action Plan (AAP)

School Health Plan (SHP)
Emergency Action Plan (EAP)
Medication Authorization & Self-Administration Form
In accordance with UCA 53G-9-503 Utah Department of Health/Utah State Office of Education

PHOTO

CACHE COUNTY SCHOOL DISTRICT
Nursing & Health Services
Phone 435-752-3925
Fax 435-792-7796

RN Approval

Does student have a history of **SEVERE ALLERGY (ANAPHYLAXIS)** where epinephrine was used? ☐ Yes ☐ No
IF YES, please also complete Allergy Action Form Allergy to:_____

STUDENT INFORMATION

Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Email:		
School Nurse:	Phone:	Email:		

SEVERITY CLASSIFICATION

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

TRIGGERS

☐ Illness ☐ Exercise ☐ Animals ☐ Smoke ☐ Dust ☐ Food ☐ Weather ☐ Air Quality ☐ Pollen ☐ Other:

AIR QUALITY
Student should stay indoors when Air Quality Index is:

☐ Moderate	☐ Unhealthy for Sensitive groups	☐ Unhealthy	☐ Other:

EXERCISE
Take quick-relief medication (see medication order in Yellow section below):
☐ Before exercise/exposure to a trigger
☐ Other (specify):

GREEN: DOING GREAT!

Student has **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Able to work and play normally

ACTION

Controller medication (taken at home)	How much?	How often?

Yellow: Mild to Moderate Distress

Student has **ANY** of these:
- Coughing or wheezing
- Tight Chest
- Shortness of breath

ACTION

Quick-relief medication	How much?	How often?
Administer Via		
☐ Inhaler ☐ Nebulizer ☐ Inhaler with spacer	☐ Student is independent ☐ Student needs assistance ☐ Student needs supervision	

1. Restrict physical activity and allow to rest upright.
2. Do not leave student unattended. Observe continuously for 15 minutes.
3. Notify parent/guardian.
4. If improved (breathing smooth and easy, no coughing or wheezing) may return to class.
5. **If no improvement CALL EMS and move to RED section below.**

Red: Severe Respiratory Distress

Student has **ANY** of these:
Trouble eating, walking or talking
Breathing hard and fast
Medicine isn't helping
Rib or neck muscles show when breathing in
Color changes in lips, nail beds, skin

ACTION

Repeat ____ puffs of quick-relief medication (each 15-30 seconds apart) every ____ minutes until medical help arrives.
Encourage slow breaths and allow individual to rest.
Update parent/guardian.
Do not leave student unattended. Observe continuously until EMS arrives.
☐ Additional Orders (specify):

PRESCRIBER TO COMPLETE

The above-named student is under my care and has the medical diagnosis of asthma. The information contained in this document reflects my plan of care for the above-named student.

☐ **It is** medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.

☐ **It is not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT TO COMPLETE

PARENTAL RESPONSIBILITIES (Parent must sign in both places)

1. The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
2. The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.
3. If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before the designated staff can administer the updated asthma medication prescription.

PARENT/GUARDIAN AUTHORIZATION (Parent must sign in both places)
Checked boxes must match with Health Care Provider Order above

☐ **I authorize** my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.

☐ **I authorize** the appropriate/designated school personnel to maintain my child's medication for my student to self-administer in an emergency.

☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

Parent Signature:	Date:

As parent/guardian of the above-named student, I give my permission to the District Nurse and other unlicensed, trained and designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instruction as written in the emergency action plan above. Only staff trained by the school nurse for the current school year have been delegated to provide cares. Parent and student are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider and the District Nurse necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent to notify District Nurse whenever there is any change in the student's health status or care. **This authorization order is effective for one year from licensed medical provider's signature date or earlier stop date _____. This document is not valid and no specific accommodations will be made until signed by all parties.**

Parent Signature:		Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE (or school office staff, health aide)

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Inhaler is kept: ☐ Front Office ☐ Student Carries ☐ Backpack ☐Other (specify):

This health care plan is to be distributed via PowerSchool or as needed by **front office** to all "need to know" staff.

School Nurse Signature:	Date: