Liberty County School System

ASTHMA ACTION PLAN / MEDICATION ORDERS

Page 1 To Be Completed By Healthcare Provider. Page 2 To be Completed By Parent / Guardian

Student_____**Birthdate**_____**School/Teacher**_____

Asthma Severity: □ Intermittent □ Mild Persistent □ Moderate Persistent
□ Severe Persistent □ Many / severe attacks or exacerbations

Asthma Triggers: □smoke □pets □ mold □ dust-mites □ pollen/trees □colds/viruses □ exercise□ seasons

Other:_____

Child may self-carry inhaler ☐ Yes □No *(If child unable to self-treat, a nurse or trained adult will administer inhaler)*

Preferred Hospital_____ _____

MEDICATIONS/DOSES TO BE GIVEN AT SCHOOL:

Exercise Inhaler _____ Dose _____ puffs 15-30 minutes before activity as needed.

Rescue Inhaler _____ Dose_____ puffs every four hours as needed. May repeat in 10-15 minutes if no improvement after initial treatment.

Rescue Nebulizer _____ Dose_____Frequency_____

AUTHORIZATION BY HEALTHCARE PROVIDER:

Healthcare Provider Printed Name_____ **Phone Number**_____

Healthcare Provider Signature_____ **Date**_____ **Fax Number**_____

IMMEDIATE ACTION IS REQUIRED WHEN STUDENT EXHIBITS ANY OF THE FOLLOWING SYMPTOMS:
Shortness of Breath * Repetitive Cough * Chest Tightness * Wheezing / Retractions * Inability to speak in sentences

STEPS TO TAKE DURING AN ASTHMA EMERGENCY:

1. Give rescue medications as listed above.
2. Reassess in 10-15 minutes.
3. If student is back to baseline may return to class. If asthma symptoms persist continue rescue meds every 15-30 minutes until EMS arrives. Notify parent / guardian.
4. **Activate EMS if:** no relief from first dose of rescue med, lips or nailbeds are blue/ gray, too short of breath to talk normally, chest/neck pulling with breathing, or struggling to breathe.

***This action plan is good for school year 2022-2023 ONLY. Student must have new action plan every school year.**
Liberty County School System Fax Number: 912-877-4302

ASTHMA ACTION PLAN

This Page To Be Completed By Parent / Guardian

Student_____Birthdate_____School/Teacher_____

Parent / Guardian Authorizations / Responsibilities

- I want this asthma plan implemented for my child and I will provide at school medication as ordered.
- I will notify the school immediately if the medication is changed and provide new physician orders.
- I understand that the school cannot give any medications without a physician order.
- I will provide the school with an originally labeled prescription marked **"for school use".**
- I have administered at least one dose of the prescribed medication at home.
- I understand medications must be transported to the school by an adult. Student MAY NOT bring medications to school.
- I give permission for exchange of confidential information and consent for release of health information between medical provider and school district regarding my child's asthma and medications.
- I understand all medications must be picked up at the end of the school year or school will dispose them.

Child may self-carry inhaler ☐ Yes ☐No *(Physician must also authorize for child to self-carry)*

Parent / Guardian Printed Name_____Cell Phone Number_____

Parent / Guardian Signature_____ Work Number_____

Email address_____

OTHER EMERGENCY CONTACTS

Name	Relationship	Cell Phone Number	Work Number

Action Plan Reviewed By_____ Date_____

School Nurse