Akron Children's Hospital

SCHOOL ASTHMA TREATMENT PLAN FOR:

Name: _____

DOB: _____ Last Updated/Reviewed On: _____

Your Asthma Provider: _____

Provider Phone: (_____) _____ - _____

Asthma Type *(circle one)*: Intermittent / Mild Persistent / Moderate Persistent / Severe Persistent

Asthma Triggers: _____

Remember! Except for RespiClick, always use a spacer with your inhaler!

Quick Relief Medicines are Albuterol and Levalbuterol. ALBUTEROL is also known as ProAir, Ventolin, Proventil and RespiClick. LEVALBUTEROL is also known as Xopenex.

If more than 2 doses of quick relief medicine are given in 1 day: Notify School Nurse and parents/guardian!

DAILY TREATMENT PLAN

For coughing, wheezing or exercise symptoms not due to illness take: QUICK RELIEVER – 2 puffs–Inhalation–Right away.

☐ 15-20 min before sports or play give:

QUICK RELIEVER: ☐**ALBUTEROL** ☐**LEVALBUTEROL** ☐**RESPICLICK** (no spacer) - 2 puffs - Inhalation

-OR- ☐**NEBULIZER - Albuterol or Levalbuterol** - 1 vial - Inhalation

Do not give extra QUICK RELIEVER before 4 hours unless the child has symptoms.

For example: If a child has recess at 10am and then has gym at 12pm,
only give QUICK RELIEVER 15 minutes before the 10am activity because the dose should last until 2pm.

EXCEPTION: You may give a 2nd dose if the child has symptoms.

If symptoms do not improve, use SICK TREATMENT PLAN.

SICK TREATMENT PLAN

FOR Symptoms (any of these): 1) Increased cough or wheeze 2) Tight chest 3) Shortness of breath 4) First sign of a cold

Use QUICK RELIEVER: ☐**ALBUTEROL** ☐**LEVALBUTEROL** ☐**RESPICLICK** (no spacer) - 2 puffs – Inhalation - Right Away

-OR- ☐**NEBULIZER - Albuterol or Levalbuterol** - 1 vial – Inhalation - Right away

When administering QUICK RELIEVER:

- If symptoms improve after 15 minutes: OK to return to normal activity.
- If symptoms do not improve after 15 minutes: Give 2nd dose of QUICK RELIEVER, Call School Nurse and parent/guardian.
- **If symptoms get worse or do not improve after 2nd dose: Call EMS (911), School Nurse and parents/guardian, AND use EMERGENCY plan.**

EMERGENCY PLAN

FOR More Serious Symptoms (any of these):

1) QUICK RELIEVER not helping or not lasting 4 hours
2) Hard to walk or talk
3) Nasal flaring
4) The skin between the ribs and above the collarbone pulls in or retracts when breathing
5) Lips or fingernails turn blue

Use QUICK RELIEVER: ☐**ALBUTEROL or** ☐**LEVALBUTEROL** or ☐**RESPICLICK** (no spacer)

Check one: ☐2 ☐4 ☐6 puffs – Inhalation -OR- ☐**NEBULIZER-Albuterol or Xopenex** - 1 vial - Inhalation

Right away and repeat every 15 minutes for 2 more doses.

MEDICAL ALERT!

If still in Emergency zone after 15 minutes this could be a life-threatening emergency.
Take another dose of QUICK RELIEVER medicine AND call EMS (911).

We have instructed the patient and family in proper use of QUICK RELIEVER medicines. It is my professional opinion that the student:

☐ should not carry/self-administer inhaled medicine. Medicine should be stored/administered by designated school personnel.

☐ should be allowed to carry inhaled medicine and use medicine with help only.

☐ should be allowed to carry/self-administer inhaled medicine.

Provider Name: _____ Date/Time: _____
Signature

_____
Printed Name

****This form will expire at the end of the 20_____ - 20_____ school year. ****

We want your child to have good control of his/her asthma. This form will be used by school staff to help your child manage his/her asthma while at school. Ohio law requires that the parent/guardian and health provider agree for your child to get asthma medicine while in school.

Directions for Parent/Guardian:

1) Complete and sign this form for your child with asthma.
2) Give this form to your child's school.
3) Complete and sign this form every school year.

To be completed by Parent/Guardian:

Name of Child: _____ DOB: ____/____/____

Child's Address: _____

_____

Child's Grade: _____ Child's School: _____

This consent follows school policy and is based on the medical advice of my child's health care provider.
I agree for my child to do one (1) of the following: ***(Check only one box.)***

☐ **No**, my child **may not carry** his/her asthma inhaler medicine. My child may only get the medicine in the school clinic/office.
☐ **Yes**, my child **may carry** his/her asthma inhaler medicine and use the medicine **with help only.**
☐ **Yes**, my child **may carry** his/her asthma inhaler medicine and use the medicine **without help.**

I agree and am responsible to:

- Make sure my child's asthma medicine is carried in its original container and labeled by a pharmacist or healthcare provider when it is used in school.
- Tell the school as soon as possible if there is a change in the use of my child's asthma medicine.
- Have my healthcare provider complete a new medication administration form for my child if his/her medicine or dose changes.
- Tell the school if my child changes healthcare providers.

I give permission for my child's healthcare provider to communicate with school staff personnel about my child's asthma treatment plan. No other part of my child's medical health will be discussed.

Parent/Guardian Name: _____ Date/Time: _____
Signature

_____
Printed Name

This form meets all the law requirements of ORC 3313.713 for students to receive medication during school.