ARISTOTLE

PREPARATORY ACADEMY

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow:
from _____
to _____

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow:
reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!
If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

_____ _____
Parent Signature Date

_____
Printed Parent Name

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PREPARATORY ACADEMY

ASTHMA EMERGENCY CARE PLAN FOR THE BUS DRIVER

CAMPUS: _____ School Year: 20____/20____

STUDENT NAME: _____ CARRIES INHALER: ___ YES ____ NO

BUS# _____ ROUTE# _____ GRADE: _____ TEACHER: _____

PARENT/GUARDIAN NAME: _____

PHONE #: _____ CELL: _____

PRESENTING PROBLEM INFORMATION:

ASTHMA – TROUBLE BREATHING - WHEEZING

EMERGENCY PLAN:

1. STOP the bus.
2. If student has their inhaler on hand have them take their inhaler.
3. Call 911 if student's condition is getting worse and you are unsure of what to do.
4. Call 911 if student can't count to 10 without taking a breath or is breathing more than 30 times a minute.
5. Report incident to school and/or parent.

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PREPARATORY ACADEMY

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***(Request for Medication Administration in School)*** from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over the counter drugs, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the doctor's written instructions.
   (Please see and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: In accordance with G.S. 115C-375.2 and G. S. 115C-47, students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to the students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse at the following number: _____.

Thank you for your cooperation,

_____

School Nurse Date

_____

Director Date

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PREPARATORY ACADEMY

The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (Request for Medication Administration in School). Return the completed form to school. A separate parent request/permission form must be completed for each medication given at school.
3. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
    a. Name of child
    b. Name of medication
    c. Date it was prescribed
    d. Dosage
    e. How the medicine is to be given at school
    f. When the medicine will be given at school
    g. Special instructions about the child receiving the medication or about the medicine itself.
    h. Until what date the medicine is to be given at school
    i. Possible side effects of the medication
    j. Possible adverse reactions to the medication
    k. Name of the health care provider and how to locate or communicate with him or her if necessary
4. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

    Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

5. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
6. Provide the school with new, labeled containers when dosage or medication changes are prescribed.
7. Retrieve all unused medications from school when medications are discontinued, and /or at end of school year (according to local written policy)
8. Maintain communication with the school staff regarding any changes in the medical treatment needed at school.

_____

Parent Signature Date

_____

Health Office Representative Date

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PREPARATORY ACADEMY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

_____

Contraindications to administration: _____

Physician *(printed)* **Name**: _____ Address: _____

Physician Contact Information: Phone: _____ Fax:_____

Physician's Signature: _____ Date: _____

**This form is invalid unless stamped and signed by the healthcare provider*

Physician's Stamp Here

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Aristotle Preparatory Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____Date: _____

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

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PREPARATORY ACADEMY

Medication Administration Record

Student Name: _____ **Medication:** _____

A separate sheet is used for each medication or treatment

Key: A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
7										
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Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

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PREPARATORY ACADEMY

Student Agreement for Self-Carried Medication

Student: _____Grade: _____ Campus: _____
Parent(s) Printed name: _____
Parent(s) Contact Numbers: _____
Health Care Provider: _____Phone Number: _____
Medication: _____ Dose and Time: _____

FOR PROVIDER

□ Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.

Asthma ___ MDI (Metered Dose Inhaler) ___MDI with spacer____

Allergic reaction _____ Epinephrine ____ Auvi-Q _____

Diabetes ____ Insulin ____ Glucose ____

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C-375.2 The student also must have this self-medication agreement on file. The students name must appear on medications and devices.

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.

Student Responsibilities

- *I will keep my inhaler/equipment, Epinephrine Auto Injector, or diabetes medication/equipment with me at school.*
- *I agree to use my inhaler/equipment, Epinephrine Auto-Injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care providers' orders.*
- *I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition*
- *I will not allow any other person to use my medication or equipment.*

Student Signature: _____Date: _____

___Emergency Action Plan complete and on file at school
___Demonstrates correct use/administration
___Verbalizes proper and prescribed timing for medication
___Agrees to carry medication
___Can describe own health condition well
___Keeps a second labeled container in health office or main office
___Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that Aristotle Preparatory Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____Date: _____

School Nurse Signature: _____ Date: _____

Director Signature: _____ Date: _____

Physician Signature: _____ Date: _____