



Nurse phone: (360)318-2176 Section 504 Accommodation Plan

Nurse Fax: (360)318-2392

Date Plan Developed/Revised/Reviewed:

Name: Birthdate: Grade: School: Bus #: Walk Drive History of anaphylaxis/severe reaction PE/Sports (Day/Time/Period): BRIEF MEDICAL HISTORY: Inhaler(s) location: OFFICE BACKPACK ON PERSON OTHER: Epi auto-injector(s) location: OFFICE BACKPACK ON PERSON OTHER:

ALL SECTIONS ON THIS PAGE TO BE COMPLETED BY STUDENT'S LICENSED HEALTHCARE PROVIDER (LHP):

ASTHMA TREATMENT INSTRUCTIONS:

Asthma / Triggers: None known Animals Cold air Exercise Pollens Respiratory colds Smoke, chemicals, strong odors Other (i.e., foods, emotions, insects, etc.)

USUAL ASTHMA SYMPTOMS:

Cough Wheeze Shortness of breath Chest tightness Asking to use inhaler Other

GO ZONE (GREEN) INFREQUENT / MINIMAL SYMPTOMS

- Symptoms and/or use of quick relief medication < 2 times a week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, short of breath. Full participation in physical education and sports.

CAUTION ZONE (YELLOW) SIGNIFICANT SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED

- If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff -> Notify parents + nurse If student is coughing, wheezing and having difficulty breathing: Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. -> Notify parents + nurse if repeated. Other: Until symptoms are in the GO (green) ZONE, restrict strenuous physical activity. If NO improvement after repeated dose, call 911 - See below.

STOP ZONE (RED) CALL 911 DO NOT LEAVE STUDENT UNATTENDED

If student is very short of breath, can see ribs during breathing, difficulty walking to talking, blue appearance to lips or nails, quick relief medication not working.

Call 911

- Give 4 puffs quick relief inhaler (or nebulizer treatment) and notify parents and school nurse. This student needs Epi auto-injector for severe asthma attacks and Can carry and self-administer Epi auto-injector Needs help giving the Epi auto-injector. Other

EXERCISE PRE-TREATMENT (check all that apply)

N/A Give 2 puffs of quick relief inhaler 15-30 minutes prior to: PE Recess As needed

With no less than 2 hours between doses unless student complains of symptoms.

- May repeat 2 puffs of quick relief inhaler if symptoms occur. -> Notify parents + nurse if repeated.

Quick relief medication orders: (check the appropriate quick relief med(s)) Uses inhaler with spacer Albuterol 2 puffs (Proair, Ventolin HFA, Proventil) as needed every 4 hours for cough/wheeze Levalbuterol 2 puffs (Xopenex) as needed every 4 hours for cough/wheeze Other Epi auto-injector 0.3 mg Jr. 0.15 mg Daily controller meds: Dose Time Takes daily controller medications at home Takes daily controller medications at school

SIDE EFFECTS of medication(s): This student demonstrated correct use of the inhaler in the LHP's office as required. This student is able to carry and use inhalers. YES NO

LHP Signature: Print name: Start date: End date: Last day of school Other: Date: Telephone: Fax:

**TO BE COMPLETED BY PARENT OR GUARDIAN**

**EMERGENCY CONTACTS**

**Mother/Guardian**

**Father/Guardian**

Name:	Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Other:	Other:

**ADDITIONAL EMERGENCY CONTACTS**

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My student may carry and is trained to self-administer his/her own Epi auto-injector:  Yes  No Provide extra for office?  Yes  No

My student may carry and use his/her asthma inhaler:  Yes  No Provide extra for office?  Yes  No

- Parent:**
- I understand that the school board or the school district's employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
  - This permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that the student is not safely and effectively self-administering the medication.
  - A new LHP order/Emergency Care Plan (ECP) for asthma and parent/student agreement for an inhaler/EpiPen must be submitted each school year.
  - I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the school nurse.
  - I understand that my child may be eligible for Section 504 plan as indicated on front side of form and that I have received a copy of Parent and Student Rights.

**I have reviewed the information on this School Asthma Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions. I authorize the exchange of medical information about my child's asthma between the LHP office and school nurse.**

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

- Student:**
- I have demonstrated the correct use of the inhaler to the medical provider and/or school nurse.
  - I agree never to share my inhaler with another person or use it in an unsafe manner.
  - I agree that if there is no improvement after self-administering, I will report to an adult at school if the nurse is not available or present.

\_\_\_\_\_  
**Student Signature** **Date**

**All school-aged students who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their health care professional and kept on file in the school office (RCW 28A.210.320.370). The form must also be signed by a parent/guardian. The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose). The provider's office is encouraged to fax the plan to the student's school nurse.**

**CARRYING AND ADMINISTERING AND QUICK RELIEF INHALERS:**

► Most students are capable of carrying and using their quick relief inhaler by themselves. The student, student's parents, school nurse and health care provider should make this decision. The school nurse should also evaluate technique for effective use.

<b>For District Nurse's Use Only</b>	
Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication	
Device(s) if any, used:	Expiration date(s):
_____ <b>School Nurse Signature</b>	_____ <b>Date</b>
_____ <b>Principal's Signature</b>	