Seattle Public Schools

ASTHMA MEDICATION ORDER AND HEALTH HISTORY

School Year _____

STUDENT'S LAST NAME:	**STUDENT'S FIRST NAME:**	**Date of Birth:**

Grade:	**School:**

Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. Students with a life-threatening condition will be referred to the 504 Team for evaluation. (WAC 392-380-045, RCW 28A.210.320, SPS Superintendent Procedure 3413SP).

This Section To Be Completed By A Licensed Healthcare Provider (LHCP)

Asthma Diagnosis: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Usual Asthma Symptoms: ☐ Cough ☐ Wheeze ☐ Shortness of Breath ☐ Chest Tightness
☐ Asking to use inhaler ☐ Other: _____

Asthma Triggers: ☐ Exercise ☐ Cold Air ☐ Respiratory illness ☐ Pollen
☐ Poor Air Quality ☐ Smoke, chemicals, strong odors ☐ Other: _____

Medication Orders:

☐ Albuterol inhaler (Proair®, Ventolin HFA®, Proventil) ☐ Levalbuterol inhaler (Xopenex®)
Medication side effects: restlessness, irritability, jitteriness, nervousness, increased heart rate

Dose: ☐ 2 puffs ☐ 4 puffs

Time: ☐ Daily, indicate time: _____

☐ As needed, for asthma symptoms

☐ Pre-exercise. 15-30 minutes before exercise

Repeat Medication: ☐ No ☐ Yes, indicate how often: _____

Uses spacer with inhaler ☐ No ☐ Yes

Controller medication used at home (specify): _____

Level of Independence

☐ **Student will <u>NOT</u> self-carry. Student needs supervision and assistance.**

☐ **Student is authorized to carry and self-administer inhaler. Student has been instructed in the proper use of the inhaler and has been instructed in the proper administration and frequency of use.**

LHCP Name:	LHCP Signature	Date

Address:	Telephone #:	Fax #:

Medication order is valid for duration of current school year which includes summer school.

PARENT/GUARDIAN MUST SIGN PAGE 2

SECTION TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

Student's Name: _____ **Grade:** _____

Parent/Guardian Name: _____ **Phone #:** _____

Development of Disease and Management/Treatment

Age of onset / diagnosis of Asthma _____

Does your student use a peak flow meter use? (Frequency, Current Readings) _____

Current Asthma and Allergy Medications (Name, Dose, Frequency)

_____

How frequently does your student use their inhaler? _____

How many times in the last year has your student been treated for asthma in the doctor's office? Please describe.

_____

How many times in the last year has your student been to the Emergency Room or hospitalized for asthma? Please describe.

_____

Check the box that best describes your student's asthma symptoms:

☐ staying the same ☐ getting worse ☐ getting better

Student's Knowledge of Asthma Condition

Does your student understand their asthma triggers? ☐ Yes ☐ No

Can your student reliably report when they are experiencing distressing asthma symptoms? ☐ Yes ☐ No

Does your student know how to use their inhaler correctly? ☐ Yes ☐ No

Comments: _____

My student may carry and self-administer prescribed asthma inhaler with LHCP approval: ☐ Yes ☐ No Provide extra for office? ☐ Yes ☐ No

- I request this medication to be given as ordered by the licensed healthcare provider (LHCP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHCP/medical office staff about this plan and medication.
- I understand that the medication may not be administered by a nurse but may be administered by school staff trained and supervised by an RN.
- I release school staff from any liability in the administration of this medication at school.
- Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHCP.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- Permission to possess and self-administer any medication may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer the ordered medications.
- By law my signature indicates that I shall hold harmless and indemnify the Seattle School District No. 1, its agents, employees, and board members against all claims, judgements, or liability arising out of self-administration and self-carrying of medication by my student.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature – 18 years or older signing on own behalf (RCW 26.28.015 or RCW 70.02.130):

_____ **Date:** _____

For School District Nurse Use Only

This student has demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication.

This student may carry and self-administer their medication: ☐ Yes ☐ No

Device(s) if any, used: _____ **Expiration date(s):** _____

_____ _____

Registered Nurse Signature **Date**

Inhaler(s) location: ☐ Office ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

Date EAP Created: _____

IEP ☐ **504** ☐