LAKE ZURICH COMMUNITY UNIT School District 95

ASTHMA ASSESSMENT AND ACTION PLAN

School Year:_____/_____ **School:_____**

STUDENT:_____ Birthdate:_____ Grade_____

Elementary Teacher:_____Classroom:_____

PARENT/GUARDIAN NAME:_____PHONE_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN NAME:_____PHONE_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

In the event we are unable to reach you:

EMERGENCY PHONE CONTACT_____

(other than parent) **Name** **Relationship** **Phone**

DAILY ASTHMA ACTION PLAN

- **Indentify the things which start an asthma episode (check all that apply to student):**

❑ **Exercise**	❑ **Strong odors or fumes**	❑ **Other_____**
❑ **Respiratory infections**	❑ **Chalk dust**	
❑ **Change in temperature**	❑ **Carpets in the room**	
❑ **Animals**	❑ **Pollens**	
❑ **Food_____**	❑ **Molds**	

- **List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)**

_____

_____

- **Peak Flow Monitoring**

Personal Best Peak Flow Number:_____

Monitoring Times:_____

- **Daily Medication Plan (taken at home): GREEN ZONE- No asthma symptoms, able to do all activities, or medication to prevent exercise induced asthma**

Name **Dosage**

1._____

2._____

3._____

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ASTHMA ACTION PLAN con't **YELLOW ZONE: asthma symptoms-cough, wheeze, short of breath, limited activities**

Please complete with input from your physician.

Emergency action is necessary when the student has symptoms such as_____

_____or has a peak flow reading of_____.

- **Steps to take during an asthma episode:**
  1. **Give rescue medications listed below.**
  2. **Have student return to classroom if_____**
  3. **Contact parent if_____**
  4. **Seek emergency medical care (CALL 911) if the student has any of the following: RED ZONE:**
     - **No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.**
     - **Peak flow of_____**
     - **Fast or Hard time breathing with:**
       - **Chest and neck pulled in with breathing**
       - **Child is hunched over**
       - **Child is struggling to breathe**
     - **Trouble walking or talking**
     - **Stops playing and can't start activity again**
     - **Lips or fingernails are gray or blue**

- **Emergency Asthma Medications to be Taken at School (requires medication authorization on file):**

	Name	Dosage	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Name of physician treating your child's asthma: _____

_____

Address city phone fax

_____ _____

Physician Signature Date

Has student been instructed in:

_____Warning signs/symptoms of asthma attack? _____Use of inhaler _____Use of Peak Flow Meter?

May the school nurse contact the physician in case there are any questions or concerns in making an emergency plan for your child? Yes_____ No_____

_____ _____

Parent Signature Date

LAKE ZURICH COMMUNITY UNIT School District 95

Received / Reviewed by_____ _____

Health Office Staff Date

3.2011

School Medication Authorization Form

To be completed by the student's parent/guardian AND PHYSICIAN and kept in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN: **(for all medication except asthma inhalers)**

Physician's printed name:	
Office Address:	Office Phone: Office Fax:
Medication:	
Dosage:	Frequency:
Time medication is to be administered or under what circumstances:	
Diagnosis requiring medication:	
Intended effect of this medication:	
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?	❑ **Yes** ❑ No
Expected side effects if any:	
Time interval for re-evaluation:	
Has student been taught to self administer this medication?	❑ Yes ❑ No
Does student have your approval to administer this medication?	❑ Yes ❑ No
Other medication student is receiving:	

Physician's Signature Date

FOR ASTHMA INHALERS ONLY, AFFIX PRESCRIPTION LABEL HERE:

COMPLETE BOTH SIDES PARENT SIGNATUR REQUIRED

LAKE ZURICH COMMUNITY UNIT School District 95

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District 95 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 95), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and

2. To indemnify and hold harmless District 95 and its employees and agents any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.

_____ ★ _____

Parent/Guardian printed name Parent/Guardian signature

FOR PARENTS OF STUDENTS WHO SELF ADMINISTER MEDICATIONS

I authorize the School District 95 and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or "Epi-Pen" (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property.

I verify that my child has been instructed and can self administer his/her prescribed medication in accordance with the prescribed dosage and route. Also my child is aware of potential side effects, when medication is not effective, and when additional help is needed. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree, please initial:_____

Parent/Guardian initial

1-18-11

COMPLETE BOTH SIDES