SOUTH WESTERN SCHOOL DISTRICT

225 Bowman Road, Hanover, Pennsylvania 17331-4297 (717) 632-2500

TO: Parents/Guardian

FROM: School Nurse

RE: Asthma

Asthma is a chronic inflammatory lung disease characterized by breathing difficulties with attacks which vary from mild to life threatening. Asthma cannot be cured, but it can be controlled with proper treatment and care.

Pennsylvania law mandates that students have permission to carry inhalers and/or medications for life-threatening conditions. South Western School District revised the School Board medication policy and the Asthma Action Plan procedure to meet state regulations.

As the health care providers in the school, we are concerned that each individual asthmatic student receives the appropriate treatment and care. Attached are the three forms which **MUST** be completed before a student may bring their inhaler to school: Parent/Guardian Form, Physician Order Form, and Student Agreement Form.

Thank you for your help. If you have any questions or concerns regarding these changes, you may contact the certified school nurse in the building where your child is enrolled.

Attachment

South Western School District

ASTHMA ACTION PLAN

Student Name_____ Birth Date_____

Building/_____ Grade/____/Room

Physical Education Days &Time (to be completed by school nurse)

_____

EMERGENCY INFORMATION

I Parent/Guardian
Name_____ Home Phone_____
Work Phone_____

II Parent/Guardian
Name_____ Home Phone_____
Work Phone

Emergency Person
Name_____ Phone_____

Physician
Name_____ Phone_____

Asthma Triggers: _____ _____

_____ _____

YES____NO___ I give permission for my child to carry their inhaler and self administer this medication and will not hold the South Western School District and its personnel of any responsibility for the benefits or consequences of the medication and no responsibility for ensuring that the medication is taken. I am also aware that improper use or sharing of this medication will result in loss of this privilege.

_____ _____

Signature Parent/Guardian Date

SOUTH WESTERN SCHOOL DISTRICT

ASTHMA ACTION PLAN

STUDENT AGREEMENT

NAME_____ **BIRTH DATE**_____

SCHOOL_____ **GRADE**_____**ROOM**_____

NAME OF MEDICATION_____

I AGREE TO:

- Follow my prescribing health professional's medication orders.
-Use correct medication administration techniques.
-Make a note of when I use my medication at school.
-Not allow anyone else to use my medication under any circumstances.
-Keep a supply of my medication with me in school and on field trips.
-Notify the school nurse or health room assistant if the following occurs.
    --- My symptoms continue or get worse after taking the medication
    --- My symptoms reoccur within 2-3 hours after taking the medication
    --- I think I might be experiencing side effects from medication
    --- Other_____

I understand that permission for self-administration of medication is a privilege and improper use or sharing of the medication will result in the immediate confiscation of the medication and will result in the loss of privilege to carry the medication.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

ASTHMA ACTION PLAN

PHYSCIANS ORDERS

ALL CURRENT MEDICATIONS (INCLUDING THOSE GIVEN AT SCHOOL)

Name of Medication	Dose	Time	Side Effects

Student's Personal Best Peak Flow_____

Reportable Peak Flow_____

STEPS FOR ACUTE ASTHMA EPISODE

1._____

2._____

3._____

4._____

_____Yes_____No Student has been instructed on proper use of inhaler

_____Yes_____No Student has been instructed to report to the school nurse if repeated use of inhaler and /or symptoms persist.

_____Yes_____No Student demonstrates a cooperative attitude in all aspects of self administration.

_____

Physician's Name **Telephone Number**

_____

Physician's Signature **Date**