Little Chute Area School District
Health Services
ASTHMA

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STUDENT INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:	**BUS STUDENT**: *YES* *NO*	

ASTHMA SEVERITY & TREATMENT

ASTHMA SEVERITY:

- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent
- ☐ Had many or severe asthma attacks/exacerbations

GREEN ZONE: *(Even when feeling well, the below medicines are taken **daily**)*
Always use a spacer if the inhaler directs to

CONTROLLER MEDICINE(S): _____

CONTROLLER MEDICINE(S) AT SCHOOL: _____

RESCUE MEDICINE: _____ puffs every four hours, as needed.

EXERCISE MEDICINE: _____ puffs every 15 minutes, as needed.

YELLOW ZONE: *(Use "sick treatment" plan if cough, wheeze, shortness of breath or tight chest. Give **all** medicines below)*

RESCUE MEDICINE: _____ puffs every four hours, as needed.

CONTROLLER MEDICINE(S): _____

- ☐ Continue Green Zone Medicines: _____
- ☐ Add: _____
- ☐ Change: _____

If in the yellow zone for more than 24 hours or getting worse, follow the red zone and call the doctor right away!

RED ZONE: *(Breathing is hard and fast, ribs sticking out, trouble walking, talking or sleeping. **GET HELP NOW!**)*

ADMINISTER RESCUE MEDICINE(S) NOW!

RESCUE MEDICINE: _____ puffs every _____

TAKE: _____

If not better right away, call 911. Call the doctor any time the child is in the red zone.

ASTHMA TRIGGERS:

_____

_____

AUTHORIZATION

PARENT/GUARDIAN MEDICATION CONSENT

I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

***School Staff**: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms. Unless otherwise noted, the only controllers to be administered in school are those listed as "**given at school**" in the Green Zone:*

- ☐ The asthma provider and the parent/guardian agree the child may carry and self-administer their inhaler.
- ☐ The school nurse agrees the child may carry and self-administer their inhaler.

By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

EMERGENCY CONTACT:	**RELATIONSHIP TO STUDENT:**
(H) PHONE:	**(C) PHONE:**

PARENT/GUARDIAN SIGNATURE:	**DATE:**
ASTHMA PROVIDER NAME:	**PHONE:**
ASTHMA PROVIDER SIGNATURE:	**DATE:**
SCHOOL NURSE REVIEWED:	**DATE:**

Principal's Initials: _____ Date: _____