

Loudoun County Public Schools Asthma Action Plan / Physician's Order

Place
Student's
Picture
Here

Student's Information

Last Name: _____ First Name: _____ DOB: _____
 Student ID # _____ School: _____ Grade: _____
 Parent/Guardian: _____ Cell: _____ SY: _____

Asthma History

To be completed by a Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner)

Triggers: (Check all that apply)	Symptoms:	Asthma Severity:
<input type="checkbox"/> Illness/Colds <input type="checkbox"/> Exercise <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Smoke <input type="checkbox"/> Strong Perfumes <input type="checkbox"/> Pollen <input type="checkbox"/> Season/Weather <input type="checkbox"/> Dust <input type="checkbox"/> Mold/Moisture <input type="checkbox"/> Dog <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____ <input type="checkbox"/> Food	<input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Tightness in Chest <input type="checkbox"/> Wheezing <input type="checkbox"/> Tired/Weak <input type="checkbox"/> Other: _____	<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced

Severe Allergies: Yes (list): _____ **Allergy Action Plan:** Yes No

Medication/Doses

RESCUE:		Student may carry inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No
When to Give	Medication	Amount
<input type="checkbox"/> Cough, Wheezing, Chest, Tightness, Difficulty Breathing <input type="checkbox"/> Daily at: _____(Time)	<input type="checkbox"/> Albuterol Sulfate (ProAir, Proventil Ventolin) <input type="checkbox"/> Xopenex <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____Puff(s) every _____ hours as needed <input type="checkbox"/> Nebulizer treatment, _____ every _____ hours as needed <input type="checkbox"/> Other: _____

Directions for Repeating Doses:

- If symptoms are not relieved after initial dose:
- If symptoms reoccur before next dose is due:

Seek Emergency Medical Care (911) if:

1. No improvement 15-20 minutes after initial treatment.
2. Difficulty breathing with chest and neck pulled in
3. Blue color around mouth, or gums, or nail beds
4. Breathing is hard and fast with difficulty walking, talking or eating.
5. Decreased level of consciousness.

- **PRE-EXERCISE** The effects of a pre-exercise dose should last about 4-6 hours
- **Check One Box:** Repeat or Do Not Repeat dose if exercise reoccurs within 4 hours.

<input type="checkbox"/> 15-30 minutes Before Exercise	<input type="checkbox"/> Albuterol Sulfate (ProAir, Proventil Ventolin) <input type="checkbox"/> Xopenex <input type="checkbox"/> Other: _____	_____ Puff(s)
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Healthcare Provider's Name (Print/stamp): _____
 Healthcare Provider's Signature: _____ Date: _____
 National Provider Identifier (NPI): _____ Phone: _____

Parent/Guardian Name: _____	Phone: _____
My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.	
Parent/Guardian Signature: _____	Date: _____

To be completed by Health Office Staff	
Medication Received: _____	Expiration Date: _____
Medication received by: _____ / _____	
Health Office Staff Signature/Date	Parent Signature/Date

Loudoun County Public Schools
Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Asthmas Action Plan)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its 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 if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic specialist.
- 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 the medication, I will report to the school nurse/health clinic specialist or another appropriate adult if the nurse/health clinic specialist is not available or present.

Student's Signature Required

Date

Loudoun County Public Schools
Authorization for Medication Administration
Parent Information About Medication Procedures

1. **Medications should be taken at home** whenever possible so that the student does not lose valuable classroom time.
2. **The first dose of any NEW medication should be administered at home.**
3. If it is absolutely necessary for the student to take medication at school, an **“Authorization for Medication Administration” form** must be received for each medication and must be submitted to the Health Office staff with the medication to be administered at school. Use the appropriate form for asthma, allergy, seizure and diabetes medications. Medication will not be accepted without the appropriate form.
4. **Parents must provide written instructions from the healthcare provider for prescription medication to be administered by LCPS staff.** The “Authorization for Medication Administration” form is preferred, but the healthcare provider may use office stationary or a prescription pad with the following information:
 - Student’s name and date of birth
 - Name and purpose of medication
 - Dosage, time & route of administration
 - Duration of medication order/effective dates
 - Possible side effects/actions to take if these occur
 - Healthcare provider’s signature/date/NPI #
5. **Medications must be brought to the Health Office by a parent/guardian** (LCPS policy 8420) per Virginia Code 22.1-274. Students with diabetes, asthma, or life-threatening allergies may carry the following medications (insulin, glucagon, inhalers, epinephrine auto-injectors) throughout the school day with the written consent of the physician, school nurse and parent/guardian as indicated on the “Physician Order/Action Plan.” Otherwise, students are not permitted to transport medications to and from school or carry any medication while in school.
6. **Medication Containers:**
 - ❖ Prescription medications- must be in the original pharmacy bottle with proper label containing:
 - Student’s name
 - Name of medication
 - Time to be given
 - Dose / amount to be administered
 - Healthcare provider’s name
 - Date
 - ❖ Non-prescription medications (OTC- over-the-counter) - must be in the original packaging and include dosage instructions.
7. Prescription information on bottle label must match the healthcare provider’s information on the “Authorization for Medication Administration” form. **Ask the pharmacy to provide a properly labeled bottle for school.**
8. Staff will not cut/break pills. Parents/Guardians should cut/break pills or request the pharmacy to cut pills into the correct dose.
9. Medication must be given in its original form unless written directions from the healthcare provider states otherwise. For example- open capsule or crush pill and mix with applesauce/yogurt, etc.
10. Medications will be given no more than 30 minutes before or after the prescribed time.
11. Non-prescription medication will only be administered according to directions on the bottle or box. If a higher dosage is required, the “Authorization for Medication Administration” form must be completed and signed by the healthcare provider.
12. Medication must be stored and administered in the health office unless the criteria for self-carry are met.
13. A new “Authorization for Medication Administration” form is required at the start of the school year and each time there is a change in the dosage or time at which a medication is to be taken.
14. Parents/Guardians should not bring in more than a 60-day supply of prescription medicine at a time.
15. Any **herbal or natural alternative medications** (botanicals, oils, dietary or nutritional supplements, homeopathic medicine, phytomedicinals, vitamins, and minerals) require an “Authorization for Medication Administration” form signed by the healthcare provider and parent/guardian. This authorization does not permit the possession or use of marijuana or unregulated CBD or THC-A oil.
16. **Unused medication MUST be picked up by a parent/guardian on the last day of school or it will be destroyed.**