COLUMBUS COUNTY SCHOOLS

817 Washington St., Whiteville, NC 28472
(910) 642-5168

ASTHMA
EMERGENCY MEDICAL PLAN

_____
Name of Student

SYMPTOMS: Difficulty breathing with short inhalations and longer exhalations, rapid, shallow breathing, wheezing (high-pitched noise heard with breathing), excessive coughing (may cause vomiting), sensation of chest tightness, flaring of nostrils, tingling/numbness in fingers/toes, loss of color in lips.

INTERVENTIONS:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by physician and parent.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficultly or if medication is not effective in 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to _____ Hospital.
8. Additional instructions:

Parent/Guardian Signature: _____Date:_____

School Nurse Signature: _____Date:_____

PLEASE NOTE: If medications or inhaler are to be taken at school, a medication authorization form must be completed by parent and physician and kept at the school. These are obtained from your school nurse. This form is completed every year.

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ASTHMA SCHOOL RECORD

Name of Student_____ School_____
Grade_____ School Year_____
Parent/Guardian_____ Phone_____
_____ Phone_____
Physician_____Phone_____Hospital_____

1. Briefly describe what causes the child's asthma symptoms (weather, cold, allergies, exercise):

2. How often does the child have a bad enough asthma attack that he/she needs to see a doctor or go to the hospital?

3. Name any medication that the child takes for his/her asthma (how often and how much?):

   At home:_____

   At school:_____

4. Does your child suffer any side effects from these medications? Please list them here:

5. Name any activities/exercise in which your child CANNOT participate.

6. What does you child do at home to relieve wheezing during an asthma attack? (Please check any that apply)

   ____ Breathing exercises Takes medication: ____ Inhaler

   ____ Rest/Relaxation ____ Nebulizer

   ____ Drinks Liquids ____ Oral medications

7. Do you know what your child's baseline peak flow rate is?

   ____ Yes ____ No What is it?_____

8. How do you want the school to treat an asthma attack if it should happen?

   PLEASE READ THE EMERGENCY MEDICAL PLAN FOR ASTHMA AND ADD ANY FURTHER INSTRUCTIONS THAT YOU WISH FOR YOUR CHILD.

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Request for Medication Administration in School

To be completed by physician or licensed primary care provider:

Name of Student :_____ DOB:_____
School/Grade/Teacher_____
Medication: (each medication is to be listed on a separate form)_____
Prescribed for: _____Dosage and route: _____
Time(s) daily medication is to be given: a.m._____ p.m._____
Time(s) to give PRN (as needed) medication: _____
To be given from: (date) _____ to/through: _____
Significant Information (includes side effects, toxic reactions, reactions if omitted, take with/without food, etc.) _____
_____
Contraindications for Administration (reasons not to give):_____
If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me _____ at my office _____
print name phone number

b. Take child immediately to the emergency room at _____

FOR SELF-ADMINSTRATION -

☐Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions. [Asthma/allergic reaction ☐MDI (*Metered Dose inhaler) ☐MDI with spacer * ☐Epinephrine ☐diabetes –insulin ☐ diabetes – glucose]

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 ***The student also must have a self-medication agreement on file****.*

Date_____ Physician's Signature _____

To be completed by parent:

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked. I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____ _____ _____
Parent or Guardian's Signature Telephone Number Date

(School Use Only)
Name and title of person to administer medication (unless self-administered) _____

Approved by_____ _____
Principal's Signature Date

Reviewed by _____ _____
School Nurse's Signature Date