CENTRAL
UNIT SCHOOL DISTRICT 301

Date:__________________

To the Parent / Guardian of ____________________________________,

D301 health records indicate that your child has asthma, exercise-induced asthma, or reactive airway disease (RAD.) If this is not accurate, please notify the nurse in your building so we can update the current health record.

If this is accurate, we request your cooperation establishing a treatment and emergency plan for school. To promote health and academic success and to comply with government regulations, the following guidelines have been adopted by the district. *Choose one:*

(A) If **no medication will be kept at school**, please send documentation of the diagnosis from the healthcare provider as well as the completed Individual Healthcare Plan (IHP) form.

(B) Medications may be **kept in the health office** when:
-there are orders from the healthcare provider on the Asthma/RAD Healthcare Provider Orders/Med A form
-**and** an IHP has been completed by the parent/guardian or emancipated student & reviewed by the nurse
-**and** a copy of the prescription label is attached to the medication.

(C) An asthma rescue inhaler may be **carried by the student** (but not *self*-administered) when:
-there are orders from the healthcare provider on the Asthma/RAD Healthcare Provider Orders/Med A form
-**and** an IHP has been completed by the parent/guardian or emancipated student & reviewed by the nurse
-**and** the parent/guardian or emancipated student consents on the Authorization to Self-Carry
-**and** a copy of the prescription label & instructions for use are attached to the medication.

(D) A student may **self-administer & self-carry** an asthma rescue inhaler when **at the start of each school year**:
-an IHP has been completed by the parent/guardian or emancipated student and reviewed by the nurse
-**and** the parent/guardian or emancipated student consents on the Authorization to Self-Administer/Carry
-**and** a copy of the prescription label & instructions for use are attached to the medication.

A copy of each form is attached. Also included is a copy of the CCUSD Asthma ER Response Protocol. Please have necessary documents completed and call the nurse at your child's school to schedule a meeting to review documents and implement the plan.

Respectfully,

Central CUSD 301 Health Services Staff

Healthcare Provider Orders / Med-A for Students with **Asthma/RAD**

Name of Student ______________________________ Date of Birth:_________

School ______________________ Grade ____________ Homerm/Teacher________________

Diagnosis: ______________________________ History of anaphylaxis? No Yes

Asthma medications taken at home:_____________________________________

Triggers (circle all that apply):		
Exercise	Food	Molds
Respiratory infections	Smoke	Pollen
Changes/extremes in temperature	Animals	Humidity
Strong odors or perfumes	Chalk dust	Other:

Medication Orders for school

Medication Name	Dose	Frequency
Inhaler:		
Nebulizer:		

Additional Instructions:

Possible Side Effects:_____________________________________

Are these medications necessary in order to maintain the student at school? No Yes

Peak Flow Orders

Zone	**Signs / Symptoms**	**Student Range**	**Orders / Meds**
Personal Best	-------		--------
Green (80 -100% of Personal Best)	No cough or wheeze Can do usual activities	_______ to ________	
Yellow (50 -79% of Personal Best)	Cough, wheeze, tight chest Cannot do normal activities	_______ to ________	
Red (below 50% of Personal Best)	Medicine not helping Breathing hard & fast Cannot talk well or walk Flaring nostrils	_______ to ________	

*If needed, please provide family / student with a prescription for a **peak flow meter to be left at school.**

Provider's Name ___________________________ Ph#_____________ Fax #______________
(please print)

Healthcare Provider's Signature______________________________________ Date __________

Fax to Central CUSD 301 Health Services:

rev 2016.11

CHS	CMS	PKMS	HBT	CT	PV	LL
847-464-6039	847-464-0233	847-717-8105	847-464-6022	847-717-8006	847-464-6024	630-387-7912

INDIVIDUAL HEALTHCARE PLAN – Asthma

Name: ____ D.O.B. ____________ School __________

Grade ____________ Homeroom ____________ IHP valid from _________________ to _________________

Does student have severe allergies? No Yes Allergen & treatment:____

Any other coexisting conditions? ____

Rescue/Preventative Medication(s) at home: ____

Asthma Triggers (list): ____

Treatment/Action Plan for School (Check all that apply)

□ Call parent if symptoms or complaints— there is no medication at school

□ Medication Orders for school: ____

____

Location: □ health office □ with student □ other: ____

□ Student self-carries, but inhaler must be administered by an adult; authorization form is signed

Location of inhaler: ____ (Cannot be in locker)

□ Student self-carries and self-administers inhaler; authorization form is signed

□ Physical Activity: ____ puffs rescue inhaler 15 minutes □before gym □before recess □when/if requested

□ Obtain peak flow result if parameters & meter have been provided to school (see Zones below)

□ Other: ____

Green Zone: Doing Well	Yellow Zone: Caution	Red Zone: SEVERE-Get Help Now!
Peak flow meter ________ to ________ Symptoms: Breathing is good, no cough or wheeze, can work and play Actions: None needed at this time	Peak flow meter ________ to ________ Symptoms: Some problems breathing, cough, wheeze, short of breath, chest tightness, problems working and playing Actions: Initiate Emergency Response Protocol (see reverse)	Peak flow meter _____ to ______ Symptoms: Very fast or hard breathing, nasal flaring, blue lips or fingernail beds, medication not helping, skin sucking in at neck, ribs; cannot work or play, getting worse Actions: Call 911 Initiate Emergency Response Protocol (see reverse)

Emergency Contacts:

Name	Relationship	Cell Phone	Other (specify)

#1____

#2____

#3____

#4 Healthcare Provider: ____

Authorization: I hereby grant permission for the above named school to administer the medication routine described herein for the above named child. I further give the district nursing staff permission to be in contact with the healthcare provider with regard to the medication order and the response my child has to the medication. I hereby authorize CCUSD 301 health personnel to release my child's health information/records to teachers, administration, transportation,sports coaches, and food service personnel for the purpose of treating or preparing for a medical situation for my child. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that the records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights & Privacy Act.

Parent/Guardian Signature ____Date __________

Student Signature if emancipated____ Date __________

Signature of Nurse ____ Date__________

Authorization for Self-Administration and/or Self-Carry

of Asthma and/or Epinephrine Medication

Name of Student ______________________________ Date of Birth: ____________

School ______________________ Grade __________ Homeroom/Teacher ________________

Diagnosis ______________________ Medication ______________________

I hereby acknowledge that I am the above referenced student or the parent/legal guardian of the above referenced student and that I am primarily responsible for administering medication to said child. However, in the event that I am unable to do so, I hereby authorize Central Community Unit School District 301 to allow *(circle one or both)* **self-carry / self-administration** of the lawfully prescribed *(circle one or both)*: **asthma / epinephrine** medication during the following: (1) while in school; (2) while at a school sponsored activity; (3) while under the supervision of school personnel; and/or (4) before or after normal school activities. I attest that the student has been instructed on and is capable of self-administering and that he/she understands the need for the medicine and to report any side effects to school staff. I further attest that the above referenced student has been instructed to report each time the medicine is used during any of the above times to staff in the building.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from self-administration of asthma / epinephrine medication. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties from and against any and all claims, damages, causes of action or injury incurred or resulting from self-administration of said medication.

Print Name of Parent / Guardian ______________________________

Signature of Parent / Guardian ______________________________ Date: __________

Print Name of Emancipated Student ______________________________ D.O.B: _________

Signature of Emancipated Student ______________________________ Date: __________

Central CUSD301 Asthma Emergency Response Protocol

Student Requesting Inhaler
or
Having Symptoms

SYMPTOMS: Caution
Coughing
Wheezing
Chest tightness
Shortness of breath
Difficulty breathing
CALL NURSE

SEVERE Symptoms = one or more of:
Nasal flaring
Cannot walk or speak
Very fast or hard breathing
Blue lips or fingernail beds
Skin sucking over neck, ribs or stomach
Loss of consciousness

NO Inhaler & NO Nurse
In this order:
CALL 911
Call Parent/Guardian
Stay with student until EMS or parent arrive

INHALER available
Use Peak Flow meter if available & record result
Use Inhaler (2 puffs or per attached IHP)
Stay calm
Observe for 15 to 20 minutes for improvement
- Encourage slow deep breaths
- Remove outerwear; loosen clothing
- Student to remain seated upright
- No sleeping or lying down permitted

Use Peak Flow meter again & record result

In this order:
CALL 911
Call Nurse
Use INHALER every 10-20 minutes (or per attached IHP)
Call Parent/Guardian
Stay with student until EMS or parent arrive

Minimal or NO Improvement in 10 minutes
(still has complaints or still symptoms or Peak Flow not in Green Zone)
Worsening
(fast or hard breathing, nasal flaring, cannot walk or speak, skin sucking over neck, ribs, stomach)
Call 911
Use inhaler every 10 to 20 minutes or per attached IHP
Call Parent/Guardian
Stay with student until EMS or parent arrives

Improvement
- Reports relief
- No wheeze or cough
- Lips and nailbeds pink
- Denies chest tightness
- No difficulty breathing
- Peak Flow result in Green Zone

May return to class and resume activities

Document episode, symptoms, actions and outcome to retain in student health record.

All staff members will review this protocol and complete an in-person or online training every other year on asthma management, symptom prevention and emergency response. Furthermore, any staff likely to assist a student with asthma should review the inhaler packet insert or practice with a "trainer" under the direction of a school nurse. This document was developed based on the Illinois Asthma Episode ER Response Protocol Template of Oct 2016 in order to comply with 105 ILCS 5/22-30 j-15 & Public Act 99-0843.