Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Asthma Action Plan

Effective Date: _____

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____

MEDICATION(S) WILL NOT BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES

Parents/Guardian Information:	Relationship:	Phone Number(s):
1)		
2)		

I authorize school staff to give my child the prescribed medication and release Springs Charter Schools and staff from liability under California law. I allow the school nurse or trained staff to administer it and permit necessary health information to be shared with my child's provider.

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN TO COMPLETE

Student may Self-Administer and Self-Carry (if applicable) ☐ Yes ☐ No ☐ NA *(if **yes**, complete page 2)*

Severity Classifications	**Triggers**	**Prevent** asthma symptoms every day:
☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent	☐ Colds/Flu ☐ Dust ☐ Animals ☐ Exercise ☐ Pollen/Outdoor Mold ☐ Animals ☐ Odors/Sprays ☐ Smoke ☐ Weather/Air Pollution	• Take controller medication every day • Avoid things that make asthma worse (triggers) • Before exercise take _____ puffs of _____

Green Zone: Doing Well

Symptoms
- No cough or wheeze
- Can work/play (usual activities)
- Breathing is good

Control Meds For School

Medication Name	Dosage	Frequency

Yellow Zone: Getting Worse

Symptoms
- Some problems breathing
- Cough, wheezing, or chest tightness
- Problems working or playing
- Wake at night

Take Quick Relief Medications:

Medication Name	Dosage	Frequency

Red Zone: Medical Alert

Symptoms
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Take Quick Relief Medication (see above) **and call 911**

- **Trouble walking or talking due to shortness of breath**
- **Fingernails or lips turn blue**

Physician/HCP Name (printed): _____ Phone Number: _____

Physician/HCP Signature: _____ Date: _____ License #:_____

HEALTH SERVICES DEPARTMENT

Authorization for Self-Administered Medication at School

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____ Teacher: _____

In order for your child to carry a self-administered medication, the following conditions must be understood and agreed upon by both the student and parent/guardian: The student may use the prescribed medication as needed and as directed by their healthcare provider (HCP). The HCP's signature confirms that the student has been properly instructed on its use. The medication must be clearly labeled with the student's name. **Both the Asthma Action Plan and this document** must be signed by the parent/guardian and kept on file at the school before the student is permitted to carry the medication. ***MD signature is a recommendation; however, the campus RN has the final decision to allow self-carry medications.**

NO DIRECT MONITORING will be conducted by the school staff for self-carry medications. The student is responsible for the safe handling and self-administration of medication. The student is responsible for notifying school staff if he/she self-administer any emergency medication (i.e., epinephrine).

Parents are responsible for promptly notifying the school of any changes to their child's health status, HCP, or prescribed medications. Any change in medical procedures must be submitted in writing by the treating physician. The district is not responsible for risks associated with improper handling of medication, including overuse, incorrect administration, breakage, theft, loss, sharing, misuse, or careless storage. If a student engages in behaviors that increase safety risks to themselves or others, the current protocol may be re-evaluated.

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I authorize my child to carry the prescribed medication and release the school district and staff from liability for any adverse reaction resulting from self-administration during school hours..

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE STUDENT

I have been instructed in the proper use of my medication and will take it as prescribed. I understand that misuse may lead to disciplinary action by my School/District.

Student's Signature: _____ Date: _____

PHYSICIAN TO COMPLETE

The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the medication at school. The student has been instructed in proper medication use and is able to self-administer responsibly, understanding its purpose, method, and frequency.

Medication	Dose	Method of Administration	Time to be given	Frequency

Physician/HCP Name (printed): _____ NPI: _____

Physician/HCP Signature: _____ License Number:_____ Date: _____