***Student Health Services***

**Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Asthma Triggers (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Induced: Asthma symptoms are triggered by exercise/physical activity 🞏YES 🞏NO  
 If yes: Use rescue inhaler 2 puffs: 🞏Before very active exercise 🞏Before PE 🞏Before Recess *(per Med. Authorization)*

|  |  |
| --- | --- |
| **Yellow Zone Symptoms** | **Actions:** |
| * Coughing for prolonged periods. * Wheezing, musical sounds in chest or other unusual noises when breathing. * Shortness of breath * Tightness in chest * Can’t easily play or exercise * Can do some but not all usual activities | 1. Have student use their inhaler as prescribed:   \_\_\_\_\_\_\_\_\_ puffs, every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Remove student from trigger such as activity or allergen. 2. Calm student and encourage slow, deep breaths 3. Breath through pursed lips 4. Sips of cool water 5. If symptoms are not relieved, repeat dose as prescribed 6. If inhaler not available, call the school nurse 7. Call parent if school nurse not in campus |
| **Red Zone (Emergency) Symptoms** | **Actions:** |
| * Very short of breath * Breathing is very difficult or very fast * Using neck or stomach muscles to breathe * Nostrils are flaring/opening wide to breathe * EXTREME DANGER * Trouble walking or talking * Lips or fingers are blue | 1. CALL 911 2. Have student use their inhaler as prescribed:   \_\_\_\_\_\_\_\_\_\_\_ puffs, every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Stay with student to monitor breathing, Speak calmly and reassuringly. Encourage student to relax, sit up in a comfortable position, and take slow deep breaths. Offer sips of water ONLY if able to drink safely. 2. Contact parent/guardian. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent/Guardian Signature Phone# Date*

**Emergency contact in the event parent/guardian cannot be reached:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR SCHOOL USE ONLY**

Location of Rescue Inhaler: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student authorized to self-medicate and self-carry:  YES  NO Location of back-up inhaler : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Plan reviewed with \_\_\_\_\_\_\_\_\_\_\_\_\_, teacher \_\_\_\_\_\_\_\_\_,TA \_\_\_\_\_\_\_\_, bus driver\_\_\_\_\_\_\_ Special area teachers, \_\_\_\_\_\_\_\_\_\_\_\_\_ First Responders**

**Parental Permission and Release of Medical Information:**

* As parent/guardian of above student, I consent for the employees of Huntingdon Area School District to follow the plan and use the designated medications on my child in accordance with the instructions above.
* I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
* I understand that this plan will be shared to all those who need to know (all student’s teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form
* I hereby acknowledge that I have read, understand, and support the Emergency Health Plan.

**Release of Medical Information**

* I hereby authorize my child’s health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential medical information contained in my child’s record regarding his/her medical condition. Only school staff delivering health care services to my child in school will use this information.

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Parent/Signature Date