LEGACY
CHRISTIAN ACADEMY

Dear Parent(s),

Because each child with asthma presents a little differently and responds to different interventions, I would like to know from you how to prevent and respond to an asthmatic episode. This packet includes required forms to assist me in this endeavor

- The Asthma Action Plan- This form is necessary for me, and necessary staff, to use if your child is having an asthmatic episode. This form will be sent with LCA staff members on field trips. **A physician signature is required.**

- The Asthma IHP- The information documented on this assists us in deciding on any accommodations, if needed, to the classroom environment. This form does not require a physician signature.

- Medication form- This form is for non-prescription and prescription medications and must be completed in its entirety. Each medication, and child, requires a separate form; I cannot have multiple medications, or student names, listed on one form. All medication is to be stored in the clinic. Medications must be unexpired, unopened, and in the original container; and have a pharmacy label if it's a prescription medication. Please remember that all prescription medications must have a physician signature on the medication form. The clinic will not accept any medication unless accompanied with this completed form, and with the appropriate signatures.

- Self-Carried Medication applies only to emergency medications and is limited to JH and HS, upon physician and school nurse approval. For your child's safety we request that a backup inhaler be stored in the clinic. Students have frequently forgotten their inhaler at home or may store them in lockers making it difficult for our staff to get the medication in case of an emergency.

Please have this paperwork completed over the summer, as it can take several weeks for physicians to complete them and prepare any required prescriptions. If you have any questions, please contact your school nurse.

Jamie Hartsell, RN
School Nurse
1101 Wesley Ave.
Xenia, OH 45385
937- 352-1655 (ph)
937-352-1641 (fax)
jhartsell@legacyknights.org

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/healthcare provider _____ Phone numbers _____

■ Physician signature _____ Date _____

Severity Classification

❍ Intermittent ❍ Moderate Persistent
❍ Mild Persistent ❍ Severe Persistent

Triggers

❍ Colds ❍ Smoke ❍ Weather
❍ Exercise ❍ Dust ❍ Air Pollution
❍ Animals ❍ Food
❍ Other _____

Exercise

1. Premedication (how much and when) _____
_____
2. Exercise modifications _____
_____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- ■ Breathing is good
- ■ No cough or wheeze
- ■ Can work and play
- ■ Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- ■ Some problems breathing
- ■ Cough, wheeze, or chest tight
- ■ Problems working or playing
- ■ Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Between 50% and 80% of personal best or
_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days.
- ❍ Change your long-term control medicine by _____
- ❍ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief treatment again.
- ❍ Change your long-term control medicine by _____
- ❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

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

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Less than 50% of personal best or
_____ to _____

Go to the hospital or call for an ambulance if:

- ❍ Still in the red zone after 15 minutes.
- ❍ You have not been able to reach your physician/healthcare provider for help.
- ❍ _____

Call an ambulance immediately if the following danger signs are present:

- ❍ Trouble walking/talking due to shortness of breath.
- ❍ Lips or fingernails are blue.

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picture

Individualized Health Care Plan

Asthma

Name of Student:_____

Grade:_____ **Homeroom:**_____ **Bus rider** **yes** ☐ **no** ☐ **Bus #**____

Additional Health Concerns:_____

_____

Accommodations needed for classroom or school environment:_____

_____

Daily Asthma Management Plan

Asthma Triggers		
☐ Exercise	☐ Food	☐ Mold
☐ Respiratory infections	☐ Animals	☐ Other
☐ Changes in temperature	☐ Pollen	
☐ Strong odors	☐ Dust	

Additional Instructions:_____

_____

Student has an Emergency Action Plan: yes ☐ **no** ☐
Medication to be taken prior to exercise: yes ☐ **no** ☐ **PE Days:**_____
Peak Flow Monitoring: Personal Best Peak flow number:_____**; Monitoring Times:**_____

Medications to be taken at school:

Medication	**Amount**	**Time**

The school nurse has consent to share this information with the appropriate staff: yes ☐ **no** ☐

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature:_____ Date:_____ _____

Any revision to the student's IHP/EAP requires a new form to completed and dated by the parent.

Legacy Christian Academy
School Medication Administration Authorization Form
Prescription or Non-Prescription Medication

Legacy Christian Academy Clinic
1101 Wesley Ave., Xenia OH 45385
Phone: 937-352-1655
Fax: 937-352-1641

Student's Name: *** Only one student name per form***		Grade:
Address:		Phone
City:	State:	Zip:

Medication Name: *Only list one medication per form*	**Dosage:**
Time/Frequency of administration:	**Special instructions for administration or storage:**
Date administration is to begin:	**Date to cease:**
Severe adverse reactions that should be reported to the physician:	

Required for prescription medications only

Physician's name and address:

One or more of physician's phone number:

Phone:	**Phone:**	**Fax:**
Physician's signature:		**Date:**

This form must be completed entirely in order for medication to be administered.
All medications must be in the original container with label intact.
All prescription medications need to have the dosing information completed and signed by a physician.
Any changes to prescription medication dosage or administration need to be signed by a physician.

Emergency Medication Self Carry/Administration Authorization/Approval

Self carry/administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State Medication Policy.

Prescriber authorization for self carry/administration of emergency medication:_____
School Nurse approval for self carry/self administration of emergency medication: _____

Parent/Guardian Authorization

I/We request designated school personnel to administer the prescription medication as prescribed by the above prescriber. I/We request the designated school personnel or volunteer nurse to administer the non-prescription medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We authorize the school nurse to communicate with the health care provider if needed.

Parent/Guardian Signature_____Date:_____
Home Phone #:_____Cell Phone #_____Work Phone #_____