LICENSED HEALTH CARE PROVIDER (LHCP) ORDERS / CARE PLAN FOR ASTHMA

STUDENT'S NAME _____ Birthdate_____ Grade:_____
Transportation: ☐ Walk ☐ Car ☐ Bus # _____
Physical Education - Days & Time / Period ***(to be completed by school)*** _____

ASTHMA MANAGEMENT PLAN - Licensed Health Care Provider (*NEED TO COMPLETE ALL AREAS*)

Identify asthma triggers (*Check each that applies to this student*)

☐ Exercise ☐ Change in temperature/season
☐ Molds ☐ Respiratory infections
☐ Pollens ☐ Other _____

Will this student use a peak flow meter at school? No_____ Yes_____
If YES, students peak flow **Green zone** _____ **Yellow zone**_____ **Red zone**_____

Students Warning Signs of an Asthma Episode: _____

Routine medication to be given at school (if any).

	Medication/Route	Amount	Time of Day to be taken
1.			

****EMERGENCY ASTHMA MEDICATIONS****

	Medication / Route	Amount	Specify symptoms for when to use
1.			
2.			

PRN Time Interval for Repeating Dosage:

- If **PRN**, specify the length of time between doses: _____
- If symptoms not relieved after initial dose (do this): _____

Side Effects of medication _____

CALL 911 IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement 15-20 minutes after treatment with medication , or if condition worsens during this period
- Difficulty walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue
- Difficulty breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated for the period of _____ to _____(not to exceed current school year). It is my professional opinion that this student (CIRCLE ONE) **SHOULD / SHOULD NOT** carry and use his/her rescue medication/s/ by himself/herself at school. **I have instructed this student in the proper way to use these medications. He/she has successfully demonstrated the ability to self-administer.**

_____ _____ _____
LHCP Signature **Date** **Telephone Number**

_____ _____
LHCP Printed Name **Fax Number**

This portion to be completed by PARENT/GUARDIAN

Parent's signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician if necessary. _____
Parent/Guardian Signature Required **Date**

THE REVERSE SIDE MUST BE COMPLETED IF YOUR CHILD HAS PERMISSION TO CARRY AND SELF-ADMINISTER HIS/HER INHALER.

Parent/Student Agreement for Permission to Carry an Inhaler

(LHCP must sign that student should carry an inhaler at school on the LHCP Orders/Care Plan for Asthma)

Parent:

*** **For your child's safety , please supply the school with a back-up Inhaler**

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or the school district's employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the school administration if it is determined that your child is not safely and effectively self-administering the medication.
- A new LHCP Order/Care Plan for Asthma and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

_____ _____

Parent/Guardian's Signature Required **Date**

Parent/Guardian names: _____ _____

(Mother) **(Father)**

Phone # **Home:** _____ _____

Work: _____ _____

Cell: _____ _____

Second Contact: Name:_____ Relationship:_____

Telephone # _____

Student:)

- I can reliably identify my asthma triggers and symptoms for needing to use my inhaler.
- I have demonstrated the correct use of the inhaler to the school nurse.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after using my inhaler as prescribed, I will report to an appropriate adult or the school nurse if present.
- I will not go anywhere alone when having an asthma attack.
- I agree to keep my inhaler in the following location:_____

_____ _____

Student's Signature Required **Date**

(to be signed when the student demonstrates proper use of the inhaler to the school nurse)

_____ _____

School Nurse signature **Date**