Loudoun County Public Schools
Asthma Action Plan / Physician's Order

Place Student's Picture Here

Student's Information

Last Name: _____ First Name:_____ DOB: _____

Student ID # _____ School: _____ Grade: _____

Parent/Guardian: _____ Cell: _____ SY: _____

Asthma History

To be completed by a Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner)

Triggers: (Check all that apply)			Symptoms:	Asthma Severity:
☐ Illness/Colds	☐ Exercise	☐ Food	☐ Cough	☐ Intermittent
☐ Mold/Moisture	☐ Smoke	☐ Pollen	☐ Difficulty Breathing	☐ Mild Persistent
☐ Strong Perfumes	☐ Dog	☐ Other:_____	☐ Tightness in Chest	☐ Moderate Persistent
☐ Season/Weather	☐ Cat		☐ Wheezing	☐ Severe Persistent
☐ Stress/Emotions	☐ Dust		☐ Tired/Weak	☐ Exercise Induced
☐ Acid Reflux			☐ Other:_____	

Severe Allergies: ☐ Yes (list):_____ **Allergy Action Plan:** ☐ Yes ☐ No

Medication/Doses

The asthma provider feels the student may carry and self-administer their inhaler: ☐ Yes ☐ No

Medication	When to Give	Amount
☐ Albuterol Sulfate (ProAir, Proventil Ventolin) ☐ Xopenex ☐ Other: _____	**Rescue:** ☐ For Cough, Wheezing, Chest, Tightness, or Difficulty Breathing ☐ Daily at: _____(Time)	☐ _____Puff(s) every _____ hours as needed ☐ Nebulizer treatment, _____ every _____ hours as needed ☐ Other: _____
	Exercise: ☐ 15-20 mins before exercise **The effects of a pre-exercise dose should last about 4-6 hours.**	☐ _____Puff(s) before exercise **Check one:** If exercise reoccurs within 4 hours: ☐ **Repeat** dose ☐ **Do Not Repeat** dose

Directions for Repeating Rescue Doses:

If symptoms are not relieved after initial dose:

☐ May repeat dose after _____ minutes

If symptoms reoccur before next dose is due **(specify instructions):**

Seek Emergency Medical Care (911) if:

1. No improvement 15-20 minutes after initial treatment., or repeat dose, if ordered
2. Difficulty breathing with chest and neck pulled in
3. Blue color around mouth, or gums, or nail beds
4. Breathing is hard and fast with difficulty walking, talking or eating.
5. Decreased level of consciousness.

Healthcare Provider's Name (Print/stamp): _____

Healthcare Provider's Signature: _____ Date: _____

National Provider Identifier (NPI): _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact the prescribing healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: _____ Date: _____

To be completed by Health Office Staff

Medication Received: _____ Expiration Date: _____

Additional Equipment Received (circle): Spacer Mask Neb supplies/tubing

Medication received by: _____/_____

Health Office Staff Signature/Date Parent Signature/Date

Loudoun County Public Schools
Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Asthma Action Plan)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its 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 principal or principal's designee if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

_____

Parent/Guardian's Signature Required Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic specialist.
- 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 self-administering the medication, I will report to the school nurse/health clinic specialist or another appropriate adult if the nurse/health clinic specialist is not available or present.

_____

Student's Signature Required Date