Pasco County Schools

# Asthma Medical Management Plan

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|---|---|---|---|
| Student's Name: | Student ID: | DOB: | School Year: |
| School: | | Grade: | Home Room: |
| Parent/Guardian #1: | Home #: | Cell #: | Work #: |
| Parent/Guardian #2: | Home #: | Cell #: | Work #: |
| Parent/Guardian's E-mail Address: | | | |
| Healthcare Provider (s): | | Phone: | Fax: |

| **Green Zone: Go!** | Take these CONTROL (PREVENTION) Medicines EVERY Day |
|---|---|
| You have ALL of these:<br>• Breathing is easy<br>• No cough or wheeze<br>• Can work and play<br>• Can sleep all night<br><br>**Peak flow:** _____ to _____<br>(More than 80% of Personal Best<br>**Personal best peak flow:**<br>_____ | **Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.**<br><br>☐ **No control medicines required.**<br><br>☐Dulera _____ ☐Symbicort _____ ☐ Advair _____, ____ puff (s) ____ times a day<br>Combination medications: inhaled corticosteroid with long-acting ☐-agonist<br><br>☐ Alvesco ____ ☐ Asmanex ____ ☐ Azmacort ____ ☐ Flovent ____ ☐ Pulmicort ☐ QVAR ____ inhaled Corticosteroid or inhaled corticosteroid/long-acting ☐-agonist<br><br>____ puff (s) MDI ___ times a day **Or** ____ nebulizer treatment (s) ___ times a day ☐ Singulair or _____, take ____ by mouth once daily at bedtime Leukotriene antagonist<br><br>**For asthma with exercise, ADD:** ☐ Albuterol or _____, _____ puffs with spacer 15 minutes before exercise |
| **Yellow Zone: Caution!** | Continue CONTROL Medicines and ADD RESCUE Medicines |
| You have ANY of these:<br>• First sign of a cold<br>• Cough or mild wheeze<br>• Tight chest<br>• Shortness of breath<br>• Can do some, but not all of usual activities.<br><br>**Peak flow in this area:**<br>_____ to _____<br>(50%-80% of Personal Best) | _____, _____ puff(s) MDI **with spacer** every _____ hours as needed<br><br>Fast-acting inhaled β–agonist<br><br>**OR**<br><br>_____, _____ nebulizer treatment(s) every _____ hours as needed<br><br>Fast- acting inhaled β–agonist<br><br>**IF SYMPTOMS PERSIST MOVE TO RED ZONE – EMERGENCY!** |
| **Red Zone: EMERGENCY!** | Continue CONTROL & RESCUE Medicines and GET HELP! |
| You have ANY of these:<br>• Can't talk, eat or walk well<br>• Medicine is not helping<br>• Breathing hard and fast<br>• Blue lips and fingernails<br>• Tired or lethargic<br>• Ribs show<br><br>**Peak flow in this area:**<br>Less than _____<br>(Less than 50% of Personal) Best) | _____, ____ puff(s) MDI with spacer every _____ minutes, for _____ treatments<br>Fast-acting inhaled â–agonist<br><br>OR<br><br>_____, ____ nebulizer treatment every _____ minutes, for _____ treatments<br>Fast-acting inhaled â–agonist<br><br>**Call 911 for an ambulance!** |

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.

Parent/Guardian Signature: _____ Date: _____

Physician's/Mid-Level Practitioner's Signature: _____ Date: _____

School Health Registered Nurse Signature: _____ Date: _____

## AUTHORIZATION TO CARRY AND SELF ADMINISTER ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

Student Name (print) _____ Parent / Guardian Name (print) _____

Student Number _____ Grade _____ Name of School _____

**Name of Medication** _____

In order for your child to carry and administer his/her own inhaler/epi-pen/or pancreatic enzyme supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the Medical Management Plan, which further sets forth the parental authorization and licensed prescriber's acknowledgement concerning the self-administration of medication.

**A. To be completed by the Florida licensed healthcare provider:**

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me, in the student's Medical Management Plan, without assistance. This student should be allowed to carry and use the equipment/medication(s) listed above.

(Licensed Prescriber's Signature) (Phone Number) (Date)

**B. To be completed by the parent/legal guardian**

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, the ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's inhaler/epi-pen/or PES. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use or misuse of such medication pursuant to s. 1002.20(3)(h),(i) and/or (k).

Date _____ Parent / Guardian Signature _____

Date _____ Student Signature _____

**Pasco County Schools**
**General Guidelines for Administration of Medication at School**

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools' trained personnel to administer the following medication to:

(Name of school)

_____

(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.

(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

_____

Possible reactions / side effects: _____

_____

I hereby authorize designated Pasco County Schools' staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed.

_____ Date: _____

(Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*