Bellevue Children's Academy & Willows Preparatory School

ASTHMA - Emergency Care Plan

2022-2023

Must be completed with a Licensed Healthcare Provider

Student's Name: _____ D.O.B.: _____

HEALTH CONCERN – Asthma: A condition where a person's airways become inflamed, narrow, and produce extra mucus which causes difficulty breathing.

Licensed Healthcare Provider to complete the section below:

ASTHMA SEVERITY: ☐ **Intermittent** ☐ **Persistent:** ☐ Mild ☐ Moderate ☐ Severe	**Any severe allergy?** ☐ No ☐ Yes To what? _____
ASTHMA TRIGGERS: ☐ None known ☐ Animals ☐ Cold air ☐ Exercise ☐ Pollen ☐ Illness ☐ Smoke, odors ☐ Other: _____	**COMMON ASTHMA SYMPTOMS:** ☐ Cough ☐ Shortness of Breath ☐ Wheeze ☐ Chest tightness ☐ Asking to use inhaler ☐ Other: _____

EMERGENCY PLAN: Administer medication as directed

- If inhaler is new or hasn't been used in 2 weeks, prime the inhaler (4 puffs). If using Xopenex prime the inhaler (4 puffs) if it hasn't been used in 3 days. Do NOT prime Respiclick.
- If student is very short of breath, has difficulty walking or talking, lips/mouth/nails are blue and quick relief medication is NOT working: **CALL 911**

MEDICATION ☐ Uses inhaler with spacer

☐ Albuterol (Proair®, Ventolin®, Proventil®) ☐ Proair RespiClick

☐ Levalbuterol (Xopenex) ☐ Other: _____

Medication side effects: restlessness, irritability, nervousness, increased or irregular heart rate

DOSAGE

_____ puffs every _____ hours as needed for symptoms.

If variable, please explain: _____

☐ Repeat _____ puffs of quick relief medication in _____ (minutes) if symptoms have not improved.

If no improvement after repeated dose, CALL 911 and School Nurse and do not leave student unattended. Give _____ puffs of quick relief medication, not exceeding _____ puffs.

EXERCISE PRE-TREATMENT

☐ No exercise pre-treatment needed

☐ May give _____ puffs of quick relief inhaler _____ minutes prior to:

☐ PE ☐ Recess

This student may self-carry this medication at school: ☐ Yes ☐ No

This student is trained and capable of self-administering this emergency medication: ☐ Yes ☐ No

Health Care Provider's Name (*please print*): _____ Phone: _____

Health Care Provider's Signature (***Required***): _____ Date: _____

Parent/Guardian Consent (please read carefully):

☐ I request that authorized school personnel assist my child to take the medication(s) described above. (If no box is checked, this option is the default.)

☐ I give my permission for this medical information to be shared with school staff on a "need to know" basis

☐ I request that my child be permitted to self-administer the medication(s) described above. I will hold harmless and indemnify BCA/WPS and its employees and personnel against all claims or liability arising out of the student's self-administration or carrying of medication.

☐ I am at least 18 years old and sign this form on my own behalf (RCW. 26.28.015 or RCW 70.02.130).

My signature indicates my permission for the exchange of information between school staff and the healthcare provider, and my understanding is that BCA/WPS and its staff will not incur any liability for any injury when the medication is administered in accordance with the healthcare provider's direction and Washington law. I understand this is a plan for a life-threatening condition and can only be discontinued, in writing, by a healthcare provider.

The permission to possess and self-administer medication may be revoked by the head of school or school nurse if it is determined that your child is not safely and effectively possessing and self-administering medication.

***** It is strongly recommended that extra medication be provided and stored at the office. *****

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____