

LAKE-LEHMAN SCHOOL DISTRICT
HEALTH SERVICES

ASTHMA INHALERS / EPINEPHRINE Auto-Injectors

Student Self-Administration

The School District Policy regarding the use of medication must be followed.

Asthma Inhalers or Epinephrine Auto Injectors must be accessible to students at all times during school hours.

Students, along with their parents, have the option to carry their Asthma Inhaler or Epinephrine Auto Injectors or store it in the nurse's office.

Students who possess Asthma Inhalers or Epinephrine Auto Injectors during school hours must demonstrate a mature responsibility regarding its usage to the school nurse.

The Student shall be encouraged to have their Asthma Inhaler or Epinephrine Auto Injector on their person at all times including field trips, exercise, gym classes, recess and sporting events as needed.

All school staff will allow students to use their Asthma Inhaler or Epinephrine Auto Injector when needed.

The School Nurse must be notified immediately if the either device was used during school hours.

I acknowledge that the school is not responsible for insuring the medication is taken and relieve the School District and its employees of responsibility for the benefits or consequences of the prescribed medication.

Asthma Inhaler: My student will CARRY _____ STORE IN NURSE'S OFFICE _____

Epinephrine Auto Injector: My Student will CARRY _____ STORE IN NURSE'S OFFICE _____

Please sign below and return to the school nurse:

Parent/Guardian

Date

School Nurse

Date Received

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

Name _____

School _____

Parent/Guardian _____

Parent's Phone _____

Doctor/Nurse's Name _____

Doctor/Nurse's Office Phone _____

Emergency Contact After Parent _____

Contact Phone _____

Asthma Severity: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers: Colds Exercise Animals Dust Smoke Food Weather Other: _____

TAKE THESE MEDICINES EVERYDAY

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night



Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

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IF NOT FEELING WELL

TAKE EVERYDAY MEDICINES AND **ADD** THESE RESCUE MEDICINES

Child has any of these:

- Cough
- Wheeze
- Tight Chest



Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After ___ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!

TAKE THESE MEDICINES

Child has any of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well



Peak flow below:

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature _____

Date _____

Health Care Provider Signature _____

It is my professional opinion this child should carry his/her inhaled medication by him/herself.

Adapted from the
NYC Childhood
Asthma Initiative

Adapted from
the NHLBI

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