NAZARETH AREA SCHOOL NURSES

(The fax goes directly to the nurses office)

HS fax 610-849-0863 **MS fax** 610-759-3262 **Intermediate fax** 484-292-1113

Kenneth N. Butz Jr. **ES fax** 610-849-0866 **Lower Nazareth ES fax** 610-849-0865 **Shafer ES fax** 610-849-0862

If your child needs to take medicine in school, prescription or *over-the-counter, the procedure is as follows: The Nazareth Area School District requires a physician's/psychiatrist's/dentist's written order and a parent's/legal guardian's/emancipated student's authorization for the school nurse, or in her/his absence the designee, to administer medications to students in the regular school setting and only in circumstances when the child's health may be jeopardized without it. Written authorization, signed by the physician, psychiatrist, or dentist (original or by fax) and the parent, legal guardian, or emancipated student must be provided for each separate prescription or medication being administered to each student. If dosage is changed, new written authorization is required. Authorization will terminate with the expiration date of the prescription or at the end of the school year, whichever occurs first. If the medication is discontinued, the parent or legal guardian must notify the school nurse in writing. **MEDICATION MUST BE DELIVERED TO THE SCHOOL NURSE BY THE PARENT, LEGAL GUARDIAN, AUTHORIZED ADULT DESIGNEE OR EMANCIPATED STUDENT IN THE ORIGINAL MEDICATION CONTAINER. STUDENTS ARE NOT TO HAVE MEDICATION IN THEIR POSSESSION AT ANY TIME PER SCHOOL DISTRICT DRUG AND ALCOHOL POLICY EXCEPT PHYSICIAN AUTHORIZED SELF-ADMINISTERED EMERGENCY MEDICATIONS.** It will be the responsibility of the parent, legal guardian, or emancipated student to make arrangements for administration of medication during activities away from school. Medication sent to school in violation of this policy will not be administered to a student. **Medication must be in original medication container.**

Medication Authorization (Physician/Psychiatrist/Dentist and Parent/Guardian)

_____

Student's name **Grade** **Date of birth**

_____

Physician's name printed

_____

Address

_____

Phone **Fax**

_____

Signature of Physician/Psychiatrist/Dentist **Date**

Authorization by parent/legal guardian/emancipated student

Name of Student _____ is requested to receive the above medication during school hours in order to maintain sufficient health and participation in the school program. We (I) do hereby grant permission for school staff to communicate directly with the physician/psychiatrist/dentist named above. We (I) do hereby release, discharge, and hold harmless NASD, its agents, and employees from any and all liability and claims whatsoever in connection with administration of the above medication to my child. We (I) have read and agree to follow the procedures set forth by the policy and procedure.

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Daytime Phone**

SELF-ADMINISTRATION:

The above named student has demonstrated the ability to self-administer the physician-prescribed emergency medication, as indicated by the following criteria:

1. Respond to and visually recognize his/her name.
2. Identify his/her medication.
3. Demonstrate the proper technique for self-administering his/her medication
4. Knowledge of medication side effects and agrees to report any side effects to the Nurse

Do you recommend that the student: Self-administer and carry in school? YES _____ NO _____

Only carry in school? YES _____ NO _____

ASTHMA ACTION PLAN revised January 18

Please complete the medicine and how much to take and how often to take it on the next page

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Student's name _____ Grade _____ Date _____

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	