CUMBERLAND COUNTY SCHOOLS

Asthma Medication Plan

Rev. 07/2023

MEDICATION ORDERS AND INSTRUCTIONS
TO BE COMPLETED BY THE STUDENT'S MEDICAL PROVIDER

Please check appropriate boxes ☒ and fill in the blanks. Doses must be exact; ranges will not be accepted.

Student Name: _____ Date of Birth: _____

School Name: _____ Grade: _____

Asthma Triggers: ☐ Colds ☐ Grass ☐ Pollen ☐ Weather Changes
☐ Other: _____

This patient is currently under my medical care and due to a diagnosis of asthma, the rescue medication below will need to be given during the regular school day according to the following protocol.

- **Rescue Medication:** ☐ Albuterol (pharmacy will determine generic brand) or
  ☐ Xopenex/Levalbuterol ☐ Spacer ☐ Spacer with mask

Pretreatment before exercise: students in grades K-8 may have physical education (PE) class and recess on the same day. Students in grades 6-12 may have PE class and sports are offered after school as well.

- Specify when pretreatment dose is needed: (**check all that apply**)
  ☐ PE class ☐ Recess ☐ Sports ☐ N/A
- Dose: give rescue medication MDI _____ # Puff(s) 15 minutes before exercise.
- Minimum interval between pretreatment doses: pretreatment rescue medication may be administered every _____ hours before exercise at school

Self-carry: for this student to be allowed to self-carry and self-administer rescue medication during the school day, the medical provider must complete a CCS Emergency Self-Medication Authorization Form and allow for the parent/guardian to provide a back-up inhaler to be kept at school. The student must be in **grade four or higher** and will have to demonstrate to the school nurse that they have the skill level necessary to use their emergency medication.

TREATMENT OF SYMPTOMS

YELLOW ZONE: CAUTION

Coughing, Wheezing, Chest is Tight, Short of Breath, & Difficulty Breathing - Peak Flow Range: _____ to _____

Step 1: Give rescue medication and monitor 15 minutes. Dose: MDI____ #Puffs or (1) Neb____ mg/3ml

Step 2: Give every____ hours as needed for asthma symptoms.

Step 3: If the student continues to have symptoms, or condition worsens, call the parent/guardian to notify the use of medication and report symptoms and then begin **RED ZONE** directions now.

RED ZONE: EMERGENCY

Breathing is Hard & Fast, Rib & Neck Muscles Show with Breathing, Trouble Talking, or Walking

Step 1: Give rescue medication and monitor 15 minutes. Dose: MDI____ #Puffs or (1) Neb____ mg/3ml

Step 2: Give every 20 minutes for up to one hour or until help arrives.

Step 3: Call 911, if no improvement after the first **RED ZONE** dose.
Call the parent/guardian or emergency contact.

THIS IS AN EMERGENCY!

Students needing emergency care cannot remain on campus. Seek medical attention now!

Physician's Signature: _____ Date: _____ **MD Stamp Below**

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

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TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Student Name: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

I understand that:

Prescription medications may be administered at school and must be in a pharmacy-labeled container that matches the Cumberland County Schools (CCS) Asthma Medication Plan. Medication dosage, time, and intervals must be exact.

CCS only permits students to self-carry and self-administer emergency medication during the school day if:

1. they are in fourth grade or higher,
2. they have submitted a completed CCS Emergency Self-Medication Authorization Form, and
3. they have demonstrated to the school nurse that they have the skill level necessary to use their emergency medication. (A **back-up inhaler** must also be signed into school before self administered will be authorized.

- The school nurse is available one day a week. Non-medical personnel administer medications daily.
- Prior to medication administration, the parent/guardian is required to sign the check-in/check-out log for medication. Asthma medication brought to school must be accompanied by a complete Asthma Medication Plan signed by the physician, and the parent/guardian.
- Students are not permitted to transport medication to or from school unless they are authorized to self carry.
- If medication is not available at the school, 911 will be called for emergencies.
- Medication may only be administered as ordered on the approved CCS medication form(s).
- The parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the primary medication clerk or school nurse if assistance is needed to ensure medication meets CCS protocol for Medication Administration during the day.
- Medications not picked up within two weeks of the last day of school will be discarded.

RELEASE OF LIABILITY FORM

I, _____ the parent/legal guardian of _____

enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This will expire one year from the date the physician signed: This form will expire : _____

DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was dicarded _____

By Staff Name : Staff Signature: Witness: