For _____ School Year
(expires at the end of August)

SHORELINE SCHOOL DISTRICT
PROVIDER TREATMENT PLAN AND MEDICATION ORDER FOR ASTHMA

Note: These orders *must* be renewed every year, before the beginning of each school year

Parkwood Elementary 1815 N 155th Shoreline, WA 98133	ATTENTION: Rachel Brucker, RN PHONE: 206.393.4153 FAX: 206.393.4158

Student Name:_____ Birth date _____ Grade/Grad Yr_____

LHP* Name _____ Phone_____ Fax _____

SCHOOL MEDICATION ORDERS – TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER*

Health condition requiring administration of medication (***Please circle***)*:* Asthma Other _____

Medication:_____ Dosage: _____ Route: _____ Time: _____

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Possible side effects: _____

****PLEASE COMPLETE THE ASTHMA TREATMENT PLAN BELOW****

GREEN ZONE: No coughing, no wheezing, breathing is unlabored

Controller medications to be used at home:_____

EXERCISE PRE-TREATMENT - *Complete if applicable*

1. Give ***(see dose below)*** quick-relief inhaler listed above 15-30 minutes prior to exercise:
   TWO PUFFS OR Other amount: _____
2. Give prior to ***(see below)***:
   Strenuous exercise OR Other: _____
3. Other pre-treatment instructions: _____

YELLOW ZONE: Mild/moderate symptoms (cough, wheeze, chest tightness, difficulty breathing)

1. Give **(*see dose below*)** quick-relief inhaler listed above
   TWO PUFFS OR Other amount: _____
2. Restrict strenuous physical activity until symptoms improve
3. If symptoms do not improve or are getting worse, repeat after 20 minutes (***OR other time*: _____)**
4. If symptoms do not improve after repeated dose or are getting worse (medication is not working) GO TO RED ZONE instructions

RED ZONE: Severe symptoms (*very short of breath, continuous coughing, ribs visible during breathing, trouble walking or talking, lips or nails turning pale or blue, not responding to medication)*

CALL 911 AND PARENT. DO NOT LEAVE STUDENT UNATTENDED

1. Give **(*see dose below*)** quick-relief inhaler listed above
   TWO PUFFS OR Other amount: _____
2. If symptoms do not improve or are getting worse, repeat after 20 minutes (***OR other time***: _____)
3. **Give no more than a total of _____ puffs of quick relief inhaler in one hour**

Other instructions for this student:_____

Student may carry quick-relief inhaler in backpack: ☐YES ☐ NO

Student may self-administer quick-relief inhaler: ☐YES ☐ NO

Student has demonstrated use to License Health Care Provider* ☐ YES ☐ NO

Per RCW 28.A.210.370 "Students with Asthma", students must have a written treatment plan and must demonstrate the proper use of medication prior to being granted the ability to self-administer medication at school.

*MD, DO, ARNP, PA, ND **Parent/Guardian AND Licensed Healthcare Provider MUST COMPLETE PAGE 2 →**

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from the [dates] _____ to _____ [not to exceed the current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

Licensed Health Care Provider* Signature	**Date**	**Phone**

TO BE COMPLETED BY PARENT/GUARDIAN

PARENT/GUARDIAN REQUEST: I request that the school nurse, or designated staff member, administer the medication(s) described above as directed by the above licensed health provider. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.
I give my consent for the confidential information contained on this form to be faxed to the above named school.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (print)

_____ _____
Address Phone

SCHOOL NURSE USE ONLY
Inhaler to be stored: ☐Backpack ☐Health Office ☐Other:

*MD, DO, ARNP, PA, ND