717 JORDAN PUBLIC SCHOOLS
Jordan Elementary School
815 Sunset Drive
Jordan, Minnesota 55352
952-492-2336 main | 952-492-4446 fax

NICOLE LANGHEIM | *RN, BSN, PHN, LSN*
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District Nurse
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RE: ASTHMA EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has Asthma or Reactive Airway Disease.

Please complete the **"Asthma Questionnaire"**. This will help us better understand your child's asthma. Please have your child's physician complete and sign the "School Asthma Plan and Medication Orders" on page 3 of this packet.

All medication brought to school must be in its **original package, unexpired, and must contain the original label from the pharmacy**. Any medication received that is expired or without labeling from your child's pharmacy will be sent back home.

If your child needs to carry an inhaler with him/her, your child's physician must indicate this on the order page (page 3). If your child will carry the inhaler with him/her, it is recommended that an extra inhaler is stored in the nurse's office should he/she forget their inhaler at home.

Nebulizer machines are available at the elementary and middle school.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

Thank you and please call or email us if you have any questions or concerns.

Laura Menden RN, LSN
Nicole Langheim RN, LSN
District Nurses (JES)
952-492-4278
jordannurse@isd717.org

Kelley Harmon LPN (JMS)
952-492-4232
kharmon@isd717.org

Kathy Dunham LPN (JHS)
952-492-4410
kdunham@isd717.org

Asthma Questionnaire
Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

ASTHMA HISTORY

1. How severe is your child's asthma? (circle one) 1 2 3 4 5
   Not Severe ***Severe***

2. How often does your child experience an acute asthma attack?
   ☐ 2 times a week or less ☐ More than 2 times a week ☐ Every day ☐ Constantly

3. When was the last time your child had an acute asthma attack?
   ☐ Days ago ☐ Weeks ago ☐ Months ago ☐ Years ago

4. Please identify below what may trigger an asthma attack for your child:
   ____Exercise ____Pollen ____Mold
   ____Respiratory Infection ____Animal Dander ____Cold weather
   ____Strong odors/fumes ____Food Allergies ____Other_____

5. Does your child recognize when he/she is starting to have breathing problems? ☐ Yes ☐ No

6. Does your child know when he/she needs medication to treat his/her asthma? ☐ Yes ☐ No

7. Does your child need to take asthma medication before physical activity? ☐ Yes ☐ No

8. Is your child able to self-administer asthma medication? ☐ Yes ☐ No

9. Does your child carry an inhaler with them at all times? ☐ Yes ☐ No
   ***If yes, it is recommended that an extra inhaler is kept in the nurse's office*

10. Does your child have any allergies? ☐ Yes ☐ No
    List allergies_____

11. What medications does your child take at home for asthma? _____
    _____

12. What medication will your child have at school for asthma?_____
    _____

*****If your child will have medication at school, please have your child's physician fill out and sign the medication orders on page 3. This MUST be completed before medication can be given at school.**

Parent Name _____(h) _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

School Asthma Plan and Medication Orders
Independent School District 717

Student Name: _____ DOB: _____ Grade: _____

ASTHMA TRIGGERS: Cold Weather Illness Exercise Pollen Food Allergies Animal Dander Other_____

Green Zone: Continue scheduled daily medications

Daily Medication Name_____ Dose_____Route_____Frequency_____

Daily Medication taken at: ☐ home ☐ school

Pretreatment for exercise

Give 2 puffs of quick relief med (name) _____ 15 minutes before:

☐ **Phy-Ed** ☐ **Recess** ☐ **Repeat in 4 hours if needed for additional or ongoing physical activity**

Yellow Zone: Relief medications for uncontrolled asthma

IF YOU SEE THIS:

- Difficulty breathing
- Wheezing
- Frequent cough
- Complains of chest tightness
- Unable to tolerate regular activities but still talking in complete sentences

DO THIS:

- Stop physical activity
- Give quick relief medication: (Medication name) → _____
  (Route) → ☐ 2 puffs ☐ Via spacer ☐ With spacer mask
- If no improvement in 10-15 minutes, repeat relief medication:
  ☐ 2 puffs ☐ Via spacer ☐ With spacer mask
- Student may resume normal activities once feeling better
- **If there is no quick relief medication at school**, call parent/guardian to pick up student or bring medication

Red Zone: Emergency Situation

IF YOU SEE THIS:

- Coughs constantly
- Struggles or gasps for breath
- Trouble talking (can speak only 2-3 words without taking a breath)
- Skin of chest and/or neck pull in with breathing
- Lips or fingernails are gray or blue
- Decreased level of consciousness

DO THIS:

- Give quick relief medication: (Medication name) → _____
  (Route) → ☐ 2 puffs ☐ Via spacer ☐ With spacer mask
- If no improvement in 10-15 minutes, repeat relief medication:
  ☐ 2 puffs ☐ Via spacer ☐ With spacer mask
- Follow anaphylaxis plan if student has life threatening allergy.
- Call 911 and tell attendant the reason for the call is asthma
- Call parent/guardian and school nurse
- Encourage student to stay calm, breathing in through nose and out through mouth

Check all that apply:

☐ Student understands the proper use of his/her asthma medications and may carry and use his/her inhaler at school independently

☐ Student needs supervision or assistance to use his/her inhaler.

☐ Student has life threatening allergy, refer to anaphylaxis plan.

Physician Signature_____**Date**_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent Name _____(h) _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____