



ASTHMA EMERGENCY CARE PLAN

For School Use Only

Medication: NO YES (Attach Med Form) Medication Location: _____




Copies of this ECP & Med Form, the medication, must go on all offsite activities.

TO BE COMPLETED BY PARENT/CAREGIVER

Name: _____ Date of Birth: _____ School: _____
 Grade: _____ Homeroom Teacher: _____ Room: _____
 Parent/Caregiver info: Name _____ Phone _____ Email _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Health Care Provider Treating Student for Asthma: _____ Ph: _____
 Other asthma medication used at home: _____
 Does student require inhaler before exercise: No Yes
 If yes, please specify: medication _____ to be given # _____ minutes before exercise
 Reduce exposure to the following asthma triggers: _____

Green Zone Doing Well 	SYMPTOMS <ul style="list-style-type: none"> Breathing is normal Feel good doing usual activities No cough, wheeze, chest tightness, or shortness of breath 	ACTIONS TO TAKE Student continues taking daily medication at home as prescribed GOAL: Prevent asthma symptoms every day and feel good!
Yellow Zone CAUTION! 	SYMPTOMS <ul style="list-style-type: none"> Cannot do all of your normal activities Regular breathing is a little faster than normal Slight cough, wheeze, chest tightness, or shortness of breath Mild chest congestion from cold or allergies 	ACTIONS TO TAKE Staff stays with the student. Staff remains calm and speaks softly Staff seats student in an upright position Staff to encourage student to take slow, deep breaths (“belly breathing”) Staff assists with quick relief medication (as prescribed): _____ (name of the medication, *see medication form) Staff to wait with the student for 15 minutes. If symptoms resolve and student remains in Green Zone, may return to class. Staff to call school nurse/parent/guardian to inform GOAL: Student is back in the green zone
Red Zone Medical Alert 	SYMPTOMS <ul style="list-style-type: none"> Persistent cough or wheeze Cannot walk, talk, or move well Rapid or shallow breathing Flared or enlarged nostrils Struggling or gasping for breath Difficulty Speaking Gray, dusky, or bluish color around mouth or under nails Quick relief medication hasn’t helped 	EMERGENCY! Get help! Do not leave student alone ACTIONS TO TAKE <ul style="list-style-type: none"> CALL 911 immediately and notify parents Administer CPR if breathing stops! Continue until paramedics (EMS) arrive! <ul style="list-style-type: none"> Give a copy of the student’s Emergency Card to EMS Send emergency medication with EMS

I authorize school personnel to implement this Asthma Emergency Care Plan as described. **I have completed a medication form for the quick relief medication.**

Health Care Provider Signature & NPI #

Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

Parent/Caregiver Signature

Date

**San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours**

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.

With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name _____

Student Name _____ Gender _____ Date of Birth _____
Last First

Physician/Health Care Provider's Name _____ Address _____ Telephone _____
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In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes _____ No _____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes _____ No _____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

Date Signature of Parent/Guardian Home Phone Emergency
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THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medication: _____

Form: _____ Dose & route: _____

If medicine is to be given DAILY, at what time(s): _____

If medicine is to be given WHEN NEEDED, describe indications: _____

How soon can it be repeated?: _____ Length of time this treatment is recommended: _____

List significant side effects of medication: _____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes _____ No _____

If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes _____ No _____ N/A _____

Date: _____ Signature of Authorized Health Care Provider: _____

Health Care Provider
Address Stamp (required):

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named student's medical record to and from:

<u>San Mateo Union High School District</u> School District to which disclosure is made	<u>650 North Delaware St., San Mateo, CA 94401</u> Address/City and State/Zip Code
<u>Sara Devaney, Health Services Manager</u> Contact person at School District	<u>650-558-2222 (Confidential Fax 650-762-0250)</u> Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following: All health information; or Disease-specific information as described:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

APPROVAL: _____
Printed Name Signature Date

Relationship to Patient/Student Area Code and Telephone Number