TORRANCE UNIFIED SCHOOL DISTRICT
HEALTH SERVICES

School Phone # ______________
School Fax # ______________

Symptom Based – Asthma Action Plan

Student Name: ______________ **Date of Birth:** __________ **School:** ______________

Parent/Guardian: ______________ **Home Phone:** __________ **Cellular:** ______________

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home): **Please CHECK box if needed for use at school.**

Medication		
A. "QUICK-RELIEF" Medication Name	1.	☐ For School *
	2.	☐ For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	1.	☐ For School *
	2.	☐ For School *
	3.	☐ For School *
C. BEFORE PE, Exertion: Med Name	1.	☐ For School *
	2.	☐ For School *

2. For student on inhaled medication (all students must go to Health Office for oral medications)

- ☐ Assist student with inhaled medication in Health Office*
- ☐ May self-administer/self-carry inhaler medication.* Student demonstrates competence. Contract to Carry Form Required.

3. A spacer device (e.g. Aerochamber) use is advised for all students at school.

4. Check known triggers: ☐tobacco ☐pesticides ☐animals ☐birds ☐cockroaches ☐cleansers ☐car exhaust ☐perfume ☐candles ☐mold ☐dust ☐cold air ☐exercise ☐smog ☐pollens ☐other ______________

5. Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:

Green Zone

Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities

Zone	Action for school
YELLOW ZONE **Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions**	**Action for school:** 1. Give "Quick – Relief" Medication(s)* 2. Notify Parent if symptoms are NOT relieved by medication after 15 - 20 min 3. If symptoms are NOT RELIEVED follow School Emergency Plan below 4. If symptoms are relieved, student may return to class **Notify Parent if "Quick – Relief" inhaler has been used more than two times this week (if not related to physical activity)*
RED ZONE **Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restrictions, symptoms are the same or worse after 30 minutes in Yellow Zone**	**Action for school:** **1. Give "Quick – Relief" Medication(s)** **2. If symptoms are not improved within 15 to 20 minutes by student's "Quick – Relief" medication, or symptoms become worse, follow School Emergency Plan below**

SCHOOL EMERGENCY PLAN

1. ***REPEAT*** "Quick-Relief" medication(s) now
2. ***Call 911*** – Seek emergency care
3. Contact parent/guardian and school nurse
4. **REPEAT "Quick-Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved**
5. Stay with student until paramedics arrive

Physician Name: ______________ ***Physician Signature:*** ______________ ***Date:*** ________

Address: ______________ **Phone:** ______________

City: ______________ **Zip:** ______________

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: ______________ ***Date:*** ________ **Phone Number:** ______________

* Medication at School Form Required
Revised 05/09

Torrance Unified School District
2335 Plaza Del Amo Bl.
Torrance, CA. 90509

CONTRACT TO CARRY LIFE SUSTAINING MEDICATION ON CAMPUS

School: T.H.S. Health Office : (310) 533-4396 ext. 7972 School Year: ______

I. **Contract*** applies to *life sustaining medications only.* (Check/Specify)

□ Abuterol inhaler	□ Epipen	□ Other (specify)
□ Ventolin inhaler		
□ Proventil inhaler		
□ Intal inhaler		
□ Aerochamber		
□ Peak flow meter		

Physician orders* to carry at school:
I have determined that this student is knowledgeable, responsible and independent in the usage of the above *life sustaining medication and/or equipment.*

Physician signature:__________________ Phone #:________________ Date:_________

***TUSD medication form is required for each medication/equipment, it must be attached.**

II. **Student agreements**: (please check all off as you read them)

- ☐ I understand that I am to keep this medication and/or equipment, with this on my person (pocket, purse, backpack, fanny pack), at all times except when in use.
- ☐ I will not share these medications or equipment with anyone under any circumstances.
- ☐ I will alert the teacher that I am having problem symptoms. Assistance may be needed if any symptoms persist or get worse after the first dost of medication.
- ☐ I will follow my Asthma Action Plan, ISHP or other health plan on file in the Health Office.
- ☐ I will renew this request every school year.
- ☐ I understand that non-compliance may result in a change in this plan.
- ☐ Other:____

Students signature:________________________________ Date:__________________

III. **Parent agreements:**
This signifies that I give permission for my child to carry *life sustaining medication and/or equipment* as described above. I will immediately notify the School Health Office/District Nurse of changes in my child's condition, medication(s), Asthma Action Plan, ISHP or other health plan.

Parent's signature:__________________________________ Date:__________________

III. Health Office

Signature:____________________________(Health Asst./District Nurse Date:___________

Authorization for Administering Medicine

TUSD District Policy

The purpose of allowing medication to be taken by pupils at school is to help provide for their general welfare by following instructions of their physicians. It shall be the school's responsibility to provide reasonable and prudent supervision while the pupil takes the medication. It shall be the pupil's (parent's) responsibility to take the prescribed medication in accordance with their doctor's instructions.

Policies Regarding Medication at School

According to the California State Education Code 49423, definite procedures must be followed with regard to taking medications at school.

During the regular school day, any pupil who is required to take medication prescribed by a physician must provide:

1. A written statement from the physician stating the method, amount and time in which medication is to be taken and relevant side effects.
2. A written statement from the parent or guardian of the pupil granting their permission that the physician's orders are carried out.
3. The medication in the original pharmacy container; labeled by a California pharmacist giving the student name, doctor name, drug, dosage, route of administration, and schedule.

All medication is to be kept in the health office, unless otherwise arranged with the District Nurse.

A parent or guardian can bring a prescribed medication to the school office and give it to their student directly.

This is for the protection of all students.

NOTICE – PLEASE READ BEFORE SIGNING REQUEST

A District Nurse or Health Clerk is not present at the school site at all times or on all days when the school is in session. Therefore, because emergency assistance may be provided by nonmedically trained District personnel, parents must assure that physicians provide complete, precise, legible, directions and instructions. The District is not responsible for notifying parents before or after prescribed medication is depleted or the expiration occurs. Expired medications will not be administered. This request for District assistance expires at the end of the school year in which it is made.

TORRANCE UNIFIED SCHOOL DISTRICT

School: ____________________ Health Office #: _______________, fax #: _______________

AUTHORIZATION for MEDICATION at SCHOOL

TO BE COMPLETED BY PARENT:

Last Name of Pupil, First Name ______ Grade ______ Sex ______ Date of Birth ______ School ______

The above named pupil is required to take medication prescribed by a physician during the regular school day. I request that designated School District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician regarding my child's medical condition and/or the medication prescribed for it.

Date ______ Telephone number(s) ______ Signature of Parent or Guardian ______

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Purpose of Medication ______ Name of Medication ______

Dosage Prescribed ______ Dose Form (Tablet, Liquid, etc.) ______ Time Schedule **at SCHOOL** ______

Date of Prescription ______ Length of Time This Medication Will be Necessary ______

Precise Method of Administering Medication: ______

DESCRIBE PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMENTS (PLEASE INCLUDE STORAGE INSTRUCTIONS):

______

______

There may be circumstances where it is important for the student to have the medication on their person:

☐ Yes, student to carry his/her med/inhaler **(life sustaining medications only)** on campus. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

☐ Yes, but keep a backup dosage/inhaler in the health office.

☐ No, health office is best location, student requires supervision or medication is not life sustaining.

The pupil, for whom this medication is prescribed, is under my care.

Print Name of Physician ______ Signature of Physician ______

Address ______ Telephone ______ Date ______

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE.
Please read TUSD Medication Policies on reverse side.

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