

Asthma Action Plan

Patient Name: _____ Weight _____ DOB: _____ Peak Flow: _____
 Primary Care Provider Name: _____ Phone: _____
 Primary Care Clinic Name: _____
 Symptom Triggers: _____

Asthma Severity: _____

Green Zone
"Go! All Clear!"

Peak Flow Range
(80-100% of personal best)

_____ to _____

The **Green Zone** means take the following medicine(s) every day.

Controller Medicines: _____

Dose: _____

Spacer Used: _____

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity.

Yellow Zone
"Caution..."

Peak Flow Range
(50-80% of personal best)

_____ to _____

The **Yellow Zone** means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s): _____

Dose: _____

If beginning cold symptoms, call your doctor before starting oral steroids.

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour follow RED ZONE instructions. If you are in the Yellow Zone for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone
"STOP!"
"Medical Alert!"

Peak Flow Range
(Below 50% of personal best)

_____ to _____

The **Red Zone** means start taking your Red Zone medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to the **emergency room or call 911 immediately.**

Reliever Medicine(s): _____

Dose: _____

I give my permission for this asthma action plan to be used by the following, and for them to share information with each other about my child's asthma on year beginning today, so that they can work together to help my child manage his/her asthma. This plan, when signed and dated, may replace or supplement the school's/daycare's consent to administer medication from, and allows my child's medicine to be administered at school/daycare.

<input type="checkbox"/> My child's school/School Health Office _____	<input type="checkbox"/> My child's clinic/hospital _____
<input type="checkbox"/> My child's day care provider _____	<input type="checkbox"/> Visiting nurse/Home care agency _____
<input type="checkbox"/> Insurance case management/Education program _____	<input type="checkbox"/> Coach _____

Student may carry and use this medicine at school after approval by the School Nurse
 My child is allowed to self administer medications

Date _____ Parent Signature _____
 MD/NP/PA Signature _____

Asthma Action Plan: Parent Letter

F2



Date: _____

Dear Parent/Guardian of: _____ Rm/Gr: _____

Good management of your child's asthma is important to his or her success at school. Clear communication between you and your child, your health care provider and school staff is the key to managing asthma at school. A written Asthma Action Plan developed by your health care provider and shared with the school will help keep your child safe at school. Following the Asthma Action Plan will enable your child to participate fully in school activities.

If your child has an Asthma Action Plan, please send a copy to the school health office. If your child does not have an Asthma Action Plan, please talk with your health care provider about developing one that can be shared with the school staff. It can be faxed directly to the school nurse at fax number _____.

Attached is an example of an Asthma Action Plan that could be completed by your health care provider.

If you have any questions, you may call me at _____.

Thank you!!

_____ LSN / PHN / RN

Asthma Severity Tool

The presence of any one of the features of severity is sufficient to place a patient in that category. An individual should be assigned to the most severe category in which any feature occurs (i.e. if a patient has one symptom marked in the severe persistent category and three in the mild persistent category - the patient would be classified severe persistent).

	<input type="checkbox"/> Mild Intermittent	<input type="checkbox"/> Mild Persistent	<input type="checkbox"/> Moderate Persistent	<input type="checkbox"/> Severe Persistent
Clinical Symptoms	<input type="checkbox"/> Symptoms ≤ 2 days/week <input type="checkbox"/> ≤ 2 nights/month	<input type="checkbox"/> Symptoms > 2 x/week but < 1 x/day <input type="checkbox"/> Nighttime symptoms > 2 /month	<input type="checkbox"/> Symptoms daily <input type="checkbox"/> Nighttime symptoms > 1 night/week	<input type="checkbox"/> Continuous daily symptoms <input type="checkbox"/> Frequent nighttime symptoms
Lung Function	FEV ₁ or PF $\geq 80\%$ predicted PF variability $< 20\%$	FEV ₁ or PF $\geq 80\%$ predicted PF variability 20-30%	FEV ₁ or PF $> 60\%$ $< 80\%$ predicted PF variability $> 30\%$	FEV ₁ or PF $\leq 60\%$ predicted PF variability $> 30\%$
Medication Daily Controller (medications required to maintain long-term control)	No daily medication needed <ul style="list-style-type: none"> Severe exacerbations may occur, separated by long periods of normal lung function and no symptoms. A course of systemic corticosteroids is recommended. 	<ul style="list-style-type: none"> Preferred treatment: Low-dose inhaled corticosteroids. Alternative treatment (listed alphabetically): cromolyn, leukotriene modifier, nedocromil, OR sustained release theophylline to serum concentration of 5-15mcg/ml. 	<ul style="list-style-type: none"> Preferred treatment: Low to moderate dose inhaled corticosteroid plus long acting inhaled beta2-agonist Alternative treatment (listed alphabetically): Increase inhaled corticosteroids within medium-dose range OR low to medium dose inhaled corticosteroids and either leukotriene modifier or theophylline. <hr/> If needed (particularly in pts with recurring severe exacerbations): Preferred treatment: <ul style="list-style-type: none"> Increase inhaled corticosteroids w/i medium dose range, and add long-acting inhaled beta2-agonists. Alternative treatment (listed alphabetically): Increase inhaled corticosteroids in medium dose range and add either leukotriene modifier or theophylline. 	<ul style="list-style-type: none"> Preferred treatment: High-dose inhaled corticosteroid plus long-acting inhaled B2-agonist AND, if needed, Corticosteroid tablets or syrup long term (2mg/kg/day, generally do not exceed 60mg per day). (Make repeat attempts to reduce systemic corticosteroids and maintain control w/ high dose inhaled corticosteroids).

Quick-relief medications: All Patients / all severity levels: Short-acting bronchodilator: 2-4 puffs short-acting inhaled beta2-agonists as needed for symptoms. Intensity of treatment will depend on severity of exacerbation; up to 3 treatments at 20 minute intervals or a single nebulizer treatment as needed. Course of systemic corticosteroids may be needed. Use of Short acting inhaled beta2 agonists on a daily basis, or increasing use, indicates the need to initiate or increase long-term control therapy.

Step Down: Review treatment every 1 – 6 months: a gradual stepwise reduction in treatment may be possible:

Step Up: If control is not maintained, consider step up. First, review patient medication technique, adherence and environmental control. The goal of treatment is to control asthma resulting in no limitations in activity, minimal symptoms or episodes, no emergency visits, and minimal adverse effects from medicine.

Adapted from: National Heart, Lung, and Blood Institute Expert Panel Report No. 2: Guidelines for the Diagnosis and Management of Asthma Update 2002

Asthma Severity Tool

Routine Clinical Assessment Questions:

<p>Monitoring Signs and Symptoms</p> <p>Global assessment: Has your asthma been better or worse since your last visit?</p> <p>Recent assessment: In the past 2 weeks, how many days have you:</p> <ul style="list-style-type: none"> • Had problems with coughing, wheezing, shortness of breath, or chest tightness during the day? • Awakened at night from sleep because of coughing or other asthma symptoms? • Awakened in the morning with asthma symptoms that did not improve within 15 minutes of inhaling a short-acting inhaled beta2-agonist? • Had symptoms while exercising or playing? 	<p>Monitoring Pharmacotherapy Medications</p> <ul style="list-style-type: none"> • What medications are you taking? • How often do you take each medication? How much do you take each time? • Have you missed or stopped taking any regular doses of your medications for any reason? • Have you had trouble filling your prescriptions (e.g. for financial reasons, not on formulary)? • How many puffs of your (quick-relief medicine) do you use per day? • How many _____ (name short-acting inhaled beta2-agonist) inhalers (or pumps) have you been through in the past month? • Have you tried any other medicines or remedies?
<p>Monitoring Pulmonary Function</p> <p>Lung Function</p> <ul style="list-style-type: none"> • What is the highest and the lowest your peak flow has been since your last visit? • Has your peak flow dropped below ____ L/min (80 percent of personal best) since your last visit? • What did you do when this occurred? 	<p>Side Effects</p> <ul style="list-style-type: none"> • Has your asthma medicine caused you any problems? • Shakiness, nervousness, bad taste, sore throat, cough, upset stomach.
<p>Peak Flow Monitoring Technique</p> <ul style="list-style-type: none"> • Please show me how you measure your peak flow • When do you usually measure your peak flow? 	<p>Inhaler Technique</p> <ul style="list-style-type: none"> • Please show me how you use your inhaler
<p>Monitoring Quality of Life/Functional Status</p> <p>Since your last visit, how many days has your asthma caused you to:</p> <ul style="list-style-type: none"> • Miss work or school? • Reduce your activities? • (For caregivers) Change your activities because of your child's asthma <p>Since your last visit, have you had any unscheduled or emergency department visits or hospital stays?</p>	<p>Monitoring Patient-Provider Communication and Patient Satisfaction</p> <ul style="list-style-type: none"> • What questions have you had about your asthma daily self-management plan and action plan? • What problems have you had following your daily self-management plan? • Has anything prevented you for getting treatment you need for your asthma from me or anyone else? • Has the cost of your asthma treatment interfered with your ability to get asthma care? • How satisfied are you with your asthma care? • How can we improve your asthma care?
<p>Monitoring Exacerbation History</p> <p>Since your last visit, have you had any episodes/times when your asthma symptoms were a lot worse than usual?</p> <ul style="list-style-type: none"> • If yes, what do you think caused the symptoms to get worse? • If yes, what did you do to control the symptoms? <p>Have there been any changes in your home or work environment? (e.g. new smokers or pets)?</p>	<p>Let's Review Some Important Information</p> <ul style="list-style-type: none"> • When should you increase your medications? Which medications? • When should you call me (your doctor or nurse practitioner)? • Do you know the after-hours phone number? • If you can't reach me, which emergency department would you go to?

These questions are examples and do not represent a standardized assessment instrument. The validity and reliability of these questions have not been assessed.

School Health Office Asthma Record (SHOAR) Instructions

Purpose:

- Record asthma medication
- Record Peak Flow readings
- Documentation of asthma symptoms
- Documentation of education

Instructions: (see SHOAR in total on next page)

- Complete the heading information: Student name, Student Identification Number(SIN), and room/grade.
- Complete the medication consent information.

Medication Consent	
Physician/Clinic Date:	<u>9/10/01</u>
Parent/Guardian Date:	<u>9/11/01</u>
LSN Approval Date:	<u>9/12/01</u>
LSN Review Date and Initials.:	<u>9/15 HR</u>
AAP Date:	<u>9/10/01</u>

- Complete asthma severity as written, with date assessed, on the Asthma Action Plan.
- (If there is no Asthma Action Plan, the LSN may determine the asthma severity based upon data from the Student Breathing Questionnaire or the Parent Questionnaire.)
- Complete the percentage values for the Green, Yellow and Red Zones on the upper left side of the record.
 - Obtain values from the Asthma Action Plan **OR**
 - If no Asthma Action Plan, determine Predicted or Personal Best Peak Flow (See explanation below.)

Asthma Severity Mild persistent 9/10/01

Height 50" **Predicted PF** 240

Personal Best Peak Flow (PF) _____

Zones		PF before meds = 0	PF after meds = X
Green	100%	<u>240</u>	
	90%	<u>216</u>	
	80%	<u>192</u>	
	79%	<u>190</u>	
Yellow	65%	<u>156</u>	
	51%	<u>122</u>	
	50%	<u>120</u>	
Red			

<p>Instructions for Predicted Peak Flow</p> <ul style="list-style-type: none"> • Determine student height • Use table "Predicted Peak Flow Percentage Rates" to determine student's peak flow values <p>Instructions for Personal Best Peak Flow (most accurate method of determining PF)</p> <ul style="list-style-type: none"> • During a two week period when the student's asthma is in good control, have the student come to the health office at the same time each day. • Measure the peak flow reading (the best of three good efforts). • Document the highest reading each day. • After two weeks, document the highest Peak Flow reading. (This will be 100%.) • Calculate the zones and percentages as they correspond to that highest value.

- Complete the Medication Section:
 - List daily medications, one medication per box.
 - List pre-exercise medication in a separate box.
 - List prn medications in a separate box.
 - Sign and initial in the lower left section.

Medications
<u>Flovent 110 mg. MDI 2 puffs @ 8 a.m.</u>
<u>Albuterol MDI 2 puffs 15-20 min before gym or recess</u>
<u>Albuterol MDI 2 puffs every 4 hours as needed wheeze, cough, SOB</u>

Signature and title of personnel authorized to give medications <u>Hope Restwell, LSN</u> <u>Camilla Caregiver, HSA</u>	Initials <u>HR</u> <u>CC</u>
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Zones	PF before meds = 0 PF after meds = X	Date 09/12/01	Date 09/13/01	Date 09/14/01
PF Plotting	100% <u>240</u>			
	90% <u>216</u>	220		
	80% <u>192</u>		195	X 200
	79% <u>190</u>			
	65% <u>156</u>			150
	51% <u>122</u>			
	50% <u>120</u>			
	Medications			
	<i>Flovent 110 mg. MDI 2 puffs @ 8 a.m.</i>	8A HR	8A CC	8A CC
	<i>Albuterol MDI 2 puffs 15-20 min before gym or recess</i>			
	<i>Albuterol MDI 2 puffs every 4 hours as needed wheeze, cough, SOB</i>			8A CC

Daily and/or Pre-exercise Medications:

- Write the date at the top of the column.
- Follow the column down to the box that corresponds with the medication given.
- Document the time the medication is given and write your initials next to the time.

PRN Medications:

(for students with asthma symptoms)

- Write the date at the top of the column.
- Check the student's peak flow before and after medications.
- Document the peak flow reading on the graph using "0" before meds and "x" after meds. Write in the time and your initials.

Documentation

Breath sounds — when the LSN/AN?PHN or LN listens to breath sounds, document in the space provided.

Signs and Symptoms:

- Document the symptoms (Y = present, N = absent)

Audible wheeze (Y/N)	N	Y		
Cough (Y/N)	N	N		
Able to be active (Y/N)	Y	Y		
Cough/Wheeze at night (Y/N)	N	Y		
AVN sent (Y/N)	Y	Y		

Education:

- Write the title and date of materials sent home in the box on the lower left side of the page.
- Write and date the appropriate education code (U=understands or N=needs improvement) next to the topic in the lower right box.

*Asthma materials sent home

ABC's of Asthma coloring book 9/12
What makes Asthma Worse" 9/13

Education (mark date, education code [U= understands, N= needs reinforcement], and initial)

What is asthma?	Peak flow meter techniques/charting 9/11 U/HR	AAP-knows zones and actions	Inhaler/spacer/neb technique & care 9/10 N/HR 9/12 U/CC
Meds- quick relief vs. controller	Triggers	Signs & Symptoms, warning signs	Played/did (circle) Bronkie/Airtopia/myasthma.com

Forms Completed:

- Note type and date of forms used
 - Asthma Visit Notification (AVN)
 - Parent/Guardian Questionnaire (PQ)
 - Student Breathing Questionnaire (SBQ)
 - Asthma Medical Request (AMR)

AVN 9/14 AMR _____ SBQ _____ PQ _____

Narrative notes are on the back of the form for additional documentation

**Predicted Pediatric Guide to
Peak Flow Zones for Providers
(Revised September 2000)**

Height	Predicted Peak Flow	Green Zone (100-80%)	Yellow Zone (79-50%)	Red Zone (Below 50%)
43"	147	150 – 119	118 – 74	<74
44"	160	160 – 128	127 – 80	<80
45"	173	175 – 139	138 – 87	<87
46"	187	190 – 150	149 – 94	<94
47"	200	200 – 160	159 – 100	<100
48"	214	215 – 171	170 – 107	<107
49"	227	230 – 182	181 – 114	<114
50"	240	240 – 192	191 – 120	<120
51"	254	255 – 203	202 – 127	<127
52"	267	270 – 214	213 – 134	<134
53"	280	280 – 224	223 – 140	<140
54"	293	295 – 234	233 – 147	<147
55"	307	310 – 246	245 – 154	<154
56"	320	320 – 256	255 – 160	<160
57"	334	335 – 267	266 – 167	<167
58"	347	350 – 278	277 – 174	<174
59"	360	360 – 288	287 – 180	<180
60"	373	375 – 298	297 – 187	<187
61"	387	390 – 310	309 – 194	<194
62"	400	400 – 320	319 – 200	<200
63"	413	415 – 330	329 – 207	<207
64"	427	430 – 342	341 – 214	<214
65"	440	440 – 352	351 – 220	<220
66"	454	455 – 363	362 – 227	<227
67"	468	470 – 374	373 – 234	<234
68"	482	485 – 385	384 – 241	<241
69"	498	495 – 398	397 – 249	<249
70"	510	510 – 408	407 – 255	<255
71"	525	525 – 420	419 – 262	<262
72"	539	540 – 431	430 – 269	<269

Asthma / Breathing Problem Visit Notification

F7



Date _____

Dear Parent or Guardian of: _____

Room/grade _____

Your child was seen in the health office with asthma or breathing problems with the following symptoms:

- wheezing
- persistent coughing
- shortness of breath / trouble breathing / tight chest
- peak flow in the yellow zone
- peak flow in the red zone
- other _____

The following care was given:

- quick relief medicine given Inhaler Nebulizer at _____
(time)
- rest
- other _____

Your child:

- Had a peak flow reading that: stayed in the _____ zone after treatment
- returned to class returned to the _____ zone after treatment
- remained in the health office
- other _____

Because an asthma episode may happen again, please observe your child closely.

- Please make an appointment for your child to be seen at her/his clinic (bring this form with you).
- Ask your Health Care Provider for a new or updated Asthma Action Plan (fax to _____).
- Ask your Health Care Provider regarding the need for, or adjustment of, controller medication/s.
- For your information only
- Other _____

When your child sees a Health Care Provider for asthma, please tell the school health office. Please let us know of the plan for your child's asthma care and give us a copy of the Asthma Action Plan so we can better care for your child at school.

Did you know that children with asthma should have at least 2 "Well Asthma Check-ups" every year at their clinic and get a flu shot every fall, even if they are doing well? Questions? Please call _____.

Health Service Assistant or LPN

Licensed School Nurse

Notification sent/provided via:

- Student
- US Mail
- Telephone

Asthma/Breathing Problems Visit Notification (AVN) Instructions

F8



Purpose:

- To increase communication between the School Health Office, parents/guardians, and primary care/asthma care providers.

Instructions:

- Health Office staff complete the Asthma Visit Notification form (AVN) when the student is seen in the Health Office with asthma symptoms and/or distress.
- The AVN is not completed on students with asthma who are coming in for routine pre-exercise medication, routine Peak Flow checks, for regularly scheduled daily long-term control medication (if administered at school), or other health problems unrelated to asthma.
- Retain one copy of the AVN for the licensed school nurse to review.
- The AVN is sent home with the student to give to her/his parent or guardian or is sent by U.S. mail. If you make a phone call in lieu of sending the AVN, complete the form anyway and give to the LSN.
- In addition, the LSN will phone parent/guardian if the student is seen in the Health Office ≥ 2 times a week with asthma symptoms.

Documentation:

- Document that the AVN was sent to parent/guardian on the daily log.

Asthma Medical Request / Referral

Subjective/Objective

Student _____ **Student ID#** _____ **DOB** _____
School _____ **Parent/Guardian** _____

Dear Health Care Provider _____ (name if known), this student was seen in the school health office for problems with his/her asthma. The following is a brief summary of school observations:

Presenting symptoms:
 Cough Wheeze
 Tight chest SOB
 Respiratory rate _____
 Acute respiratory distress
 Other _____

Precipitating Factors:
 Cold symptoms Exercise Cold air
 Other trigger/irritant/allergen exposure (specify) _____
 Reports not taking daily long term control medicine regularly
 Other _____

School absences this academic year: # _____
Comments: _____

Medication in the health office:
 Quick-relief medicine _____
 _____ via MDI with spacer _____ via nebulizer _____ via breath-actuated MDI
 Long term Control medicine _____
 Other _____
 No medicine is in the health office

Other data/comments:

Assessment

- To support this student's asthma management at school, please send/order/arrange:**
- Medical evaluation of this child
 - Current Asthma Action Plan signed by the health care provider (may serve as medication consent form)
 - Medication / spacer /PF meter for school (circle item)
 - Assess need for / adjustment of controller medication/s for this child
 - Home care referral (for asthma education, environmental assessment and follow-up in home)
 - Asthma Case Management (for care coordination, arranging education, transportation, follow-up)
 - Other _____
- Please respond: by _____ (date) after this child is seen in clinic

School Nurse _____ **Phone/pager#** _____ **Date** _____

Plan

- Health Care Provider Response:**
- Clinic will contact student / family to schedule an asthma check-up / evaluation
 - See attached new or revised Asthma Action Plan
 - Continue with current Asthma Action Plan
 - Medication / spacer / PF meter refill called to student's pharmacy
 - Medication/s approved for use at school (list) _____
 - Refer to PHN / Home Care / Case Management (specify agency or program, if preference) _____
 - Above request/s by school nurse is/are approved
 - Other _____

Health Care Provider name/signature _____

Clinic staff name/signature _____

Date returned _____

FAX or SEND TO fax # _____ -or- address _____



Purpose:

- To communicate about the student's asthma status/management between the Health Care Provider (HCP) and the Licensed School Nurse (LSN).

Process:

- The LSN will complete the *Asthma Medical Request* form (AMR) and/or contact the HCP when she/he has a student with asthma control or management concerns.
- The AMR should be sent to the HCP **only after parent/guardian consent is obtained**, except in the event of an emergency.
- When a student is transported by ambulance to the ED, send the *Asthma Medical Request* form along with the student. Fax copy to HCP (if known).
- When the student needs immediate care (based on the *MPS Pathway for Asthma Care*) and he/she is going to their primary clinic or urgent care, the Licensed School Nurse (LSN) should call the HCP to inform them of the referral. Send the *Asthma Medical Request* with the student and fax to the HCP.
- For situations not requiring immediate attention, fax the *Asthma Medical Request* to the clinic without calling the clinic staff to inform them of the incoming fax. Call the parent/guardian or send the *Asthma Visit Notification* form home informing parent/guardian that an *Asthma Medical Request* was faxed to clinic.

Instructions:

- The LSN will send the *Asthma Medical Request* when:
 - Student is seen in the Health Office 2 or more times a week with asthma symptoms.
 - Medication/peak flow meter/spacer are needed at school.
 - There are questions about medications.
 - Student experiences an acute asthma episode requiring immediate care.
 - Student has missed 5 or more days of school due to asthma within the current school year.
- The HCP will respond to the AMR when:
 - The HCP evaluated the student and there are changes in the student's medications at home or at school.
 - There are school activity restrictions related to the student's asthma status.
 - There are changes in the student's AAP or new AAP has been developed.
 - Referrals have been made by HCP for home care, environmental assessment, case management or specialists.
 - HCP wants follow-up education emphasized in the School Health Office.
 - There are any other recommendations for school staff.

Documentation:

- Document that "Asthma Medical Request" was sent to HCP in the Pupil Health Record narrative notes.
- Document on the Daily Log that the "Asthma Medical Request" was sent to the clinic or HCP.
- File original/copy in the Pupil Health Record.

Parent/Guardian Asthma Questionnaire

It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information on your child's asthma or breathing problems. This will help us take care of your child at school. **Please complete both sides of this form.**

Child's Name _____ Grade _____ ID # _____ Date _____

Parent/Guardian _____ Home Phone Number (_____) _____

Work Number (_____) _____ Cell/Pager Phone Number (_____) _____

Where does your child receive his/her asthma care: (Name of clinic) _____

Name of Physician or Nurse Practitioner _____ Clinic Phone # _____

Name of Insurance _____. If none, do you want information on free / low cost insurance? 1₁ Yes 1₀ No

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #):

1	2	3	4	5
Not severe			Severe	

2. How many days did your child miss school **last year** due to his/her asthma?
 0 days 1 – 2 days 3-5 days 6-9 days 10-14 days 15 or more days

3. How many times has your child been hospitalized overnight or longer for asthma in the **past 12 months**?
 0 times 1 time 2 times 3 times 4 times 5 or more times

4. How many times has your child been treated in the Emergency Department for asthma in the **past 12 months**?
 0 times 1 time 2 times 3 times 4 times 5 or more times

5. What triggers your child's asthma or makes it worse?

<input type="checkbox"/> Smoke	<input type="checkbox"/> Chalk / chalk dust
<input type="checkbox"/> Animals / pets	<input type="checkbox"/> Strong smells / perfume
<input type="checkbox"/> Dust / dustmites	<input type="checkbox"/> Foods (which ones: _____)
<input type="checkbox"/> Cockroaches	<input type="checkbox"/> Having a cold / respiratory illness
<input type="checkbox"/> Grass / flowers	<input type="checkbox"/> Stress or emotional upsets
<input type="checkbox"/> Mold	<input type="checkbox"/> Changes in weather / very cold or hot air
	<input type="checkbox"/> Exercise, sports, or playing hard

6. Does anybody in the household smoke? ₁ Yes ₀ No

7. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark an X for each season below)

	A lot	A little	None
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. In the past month, during the day, how often has your child had a hard time with coughing, wheezing or breathing,?

2 times a week or less More than 2 times a week Every day (at least once every day) Constantly (all of the time every day)

9. In the past month, during the night, how often does your child wake up or have a hard time with coughing, wheezing or breathing,?

2 times a month or less More than 2 times a month More than 2 times a week Every night

10. Does your child have a written Asthma Action Plan? Yes No Don't know

11. Does your child use a peak flow meter (something he/she blows into to check his/her lungs)? Yes No Don't know

12. Do you know what your child's personal best peak flow number is? Yes → what is it? _____ No

13. Please list the medications your child takes for asthma or allergies (everyday and as needed) or include a copy of your child's asthma action plan.

Turn Page Over →

Medications Taken at Home

Medication Name ?	How Much?	When is it Taken ?

Medications to be Taken at School

Medication Name ?	How Much?	When Should it be Taken ?

I GIVE CONSENT FOR THE ADMINISTRATION OF THE ABOVE MEDICATIONS AT SCHOOL

parent/guardian signature _____

***I UNDERSTAND THAT I ALSO NEED SIGNED PERMISSION FROM MY CHILD'S HEALTH CARE PROVIDER TO ADMINISTER MEDICATION AT SCHOOL (a signed asthma action plan will suffice).**

Please list anything else you use for your child's asthma (tea, herbs, home remedies, etc.): _____

14. How well does your child take his/her asthma medications?

- Can take medicine by self Forgets to take medicine Needs help taking medicine Not using medicine now

15. Does your child usually use a spacer or holding chamber with his metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?

- Yes No Don't know He/she uses a dry powdered inhaler so he/she doesn't need a spacer

16. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?

- Yes No Don't know

17. Do you want to talk to the school nurse more about asthma? Yes No

If so, what is the best time to call you?: Morning Afternoon Evening

Please call the Licensed School Nurse with questions:

Nurse's name _____

Phone # _____ Pager # _____

<u>For office use only:</u>	
Student Symptom	Severity assessment:
8. _____	Mi. _____
	Mi. P. _____
9. _____	Mo.P. _____
	S.P. _____

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Thank you for filling out this questionnaire.

Parent/Guardian Asthma Questionnaire Instructions

Purpose:

- The Licensed School Nurse uses the Parent/Guardian Asthma Questionnaire (PQ) to:
 - To determine if the student's asthma is **under control**.
 - To develop an appropriate **plan of care** (IHP and/or Emergency Health Plan) if appropriate.
 - To determine the student's **asthma severity level**.

Instructions:

- The Health Service Assistant (HSA), Licensed Practical Nurse (LPN), Licensed School Nurse (LSN) will give the Parent/Guardian Asthma Questionnaire (PQ) to:
 - newly identified or newly discovered students with asthma in Pre-K through 5th Grade.
 - students with asthma where more information is needed.
 - students whose asthma is out of control.
- The PQ may be sent home with the student, mailed or given to the parent/guardian.
- The HSA, LPN or LSN will write in LSN name and contact information on the back of the form.

Documentation:

- Information from the PQ is summarized in the narrative notes of the Pupil Health Record.
- The form is filed in the Pupil Health Record.
- Document Severity Level on School Health Office Asthma Record (SHOAR) and computerized health problem list.
- Document that PQ was sent home on daily log.

Parent/Guardian Asthma Questionnaire (PQ) Asthma Severity Rating Instructions

- 1) Score questions 8. and 9. as follows:

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Find the Severity Assessment box at the bottom of the questionnaire form

<u>For office use only:</u> <u>Student Symptom</u>	
<u>everity</u>	
<u>assessment:</u>	
8. _____	Mi. _____
	Mi. P. _____
9. _____	Mo.P. _____
	S.P. _____

- 2) For 8., under frequency of symptoms, score as follows:

- if the 1st box is checked, write M.I. after 8. _____ in the “For Office Use Only” box
- if the 2nd box is checked, write Mi.P after 8. _____ in the “For Office Use Only” box
- if the 3rd box if checked, write Mo.P. after 8. _____ in the “For Office Use Only” box
- if the 4th box is checked, write S.P. after 8. _____ in the “For Office Use Only” box

- 3) For 9., score as follows:

- if the 1st box is checked, write M.I. after 9. _____ in the “For Office Use Only” box
- if the 2nd box is checked, write Mi.P after 9. _____ in the “For Office Use Only” box
- if the 3rd box if checked, write Mo.P. after 9. _____ in the “For Office Use Only” box
- if the 4th box is checked, write S.P. after 9. _____ in the “For Office Use Only” box

- 4) Look at the severity assessment for 8. _____ and 9. _____ and choose the more severe of the two assessments. For example, if the score for 8. Was Mi.P. and the score for 9. Was Mo.P., you would estimate that according to the child’s symptoms, he/she currently has symptoms consistent with Moderate Persistent Asthma. Check the severity assessment line to indicate the student’s asthma severity.



Name _____ **Grade** _____ **ID #** _____ **Date** _____

1. In the **PAST MONTH**:

A. Have you heard **wheezing** in your chest when you breathe? Yes No

B. Have you had a hard time coughing, breathing or wheezing in the **daytime**? Yes No

If yes, **how often** do you have a hard time with coughing, breathing or wheezing?

- | | |
|---|---|
| <input type="checkbox"/> Two times a week or less | <input type="checkbox"/> Every day (at least once every day) |
| <input type="checkbox"/> More than two times a week | <input type="checkbox"/> Constantly (all of the time every day) |

C. **When** have you had a hard time with coughing, breathing or wheezing?

- | | |
|---|--|
| <input type="checkbox"/> In the classroom? | <input type="checkbox"/> At recess? |
| <input type="checkbox"/> When you are outside? | <input type="checkbox"/> After school? |
| <input type="checkbox"/> In Gym / Physical Education class? | <input type="checkbox"/> At home? |

D. Do you ever wake up at **night** with coughing, wheezing, or a hard time breathing? Yes No

If yes, **how often** do you wake up with coughing, wheezing, or breathing problems?

- | | |
|--|---|
| <input type="checkbox"/> Two times a month or less | <input type="checkbox"/> More than 2 times a week |
| <input type="checkbox"/> More than two times a month | <input type="checkbox"/> Every night |

E. Have you coughed or had a hard time breathing after being around **asthma triggers** such as:

(Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Smoke | <input type="checkbox"/> Chalk / chalk dust |
| <input type="checkbox"/> Animals / pets | <input type="checkbox"/> Strong smells / perfume |
| <input type="checkbox"/> Dust / dustmites | <input type="checkbox"/> Foods (which ones: _____) |
| <input type="checkbox"/> Cockroaches | <input type="checkbox"/> Having a cold |
| <input type="checkbox"/> Grass / flowers | <input type="checkbox"/> Stress or emotional upsets |
| <input type="checkbox"/> Mold | <input type="checkbox"/> Changes in weather / very cold or hot air |

F. Have you felt **scared** or **worried** about having problems breathing? Yes No

If yes, did you talk about it with someone? Yes No

2. A. Do you smoke? Yes No Sometimes
- B. Do your friends smoke? Yes No Sometimes
- C. Does anyone smoke at home? Yes No Sometimes

3. **What do you do** when you have breathing problems?

- | | | |
|--|--|---|
| <input type="checkbox"/> Stop and rest | <input type="checkbox"/> Tell an adult | <input type="checkbox"/> Take my quick-relief inhaler |
| <input type="checkbox"/> Drink something | <input type="checkbox"/> Call my mom or dad | <input type="checkbox"/> Do deep slow breathing |
| <input type="checkbox"/> Tell a friend | <input type="checkbox"/> Call my doctor or nurse | <input type="checkbox"/> Go to the emergency room or hospital |

4. Do you take any **medication** for your asthma/breathing problems? Yes No Sometimes

A. If yes or sometimes, when do you take it? (Check all that apply)

- When I cough or have breathing problems
- Before recess, physical education class, or sports
- Every day, even when I am feeling well, to prevent asthma symptoms

B. List the **name** of your inhalers or medicines, or **what do they look like** (what color, size).

C. How often do you take your inhalers or medicines?

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D. If yes or sometimes, when do you take it? (Check all that apply)

- When I cough or have breathing problems
- Before recess, physical education class, or sports
- Every day, even when I am feeling well, to prevent asthma symptoms

E. List the **name** of your inhalers or medicines, or **what do they look like** (what color, size).

F. How often do you take your inhalers or medicines?

5. Do you use a **spacer** (tube that attaches to inhaler) with your inhaler? Yes No Sometimes

6. Do you use a **Peak Flow meter** (thing you blow into to check lungs)? Yes No Sometimes

7. A. Where do you usually go to take care of your asthma? _____

B. When was the last time you were there? _____

8. Do you have **one main doctor or nurse practitioner** who usually checks your asthma? Yes No

9. **If you have problems** with your breathing:

A. Do you ever have a hard time getting to the doctor / clinic if you need to go?

Yes No

B. Is there a working telephone at home to call the doctor / clinic?

Yes No

If yes, what is your **phone number**? _____

10. In the **last year**, have you:

A. Stayed overnight in the **Hospital** because of breathing problems or asthma?

B. Gone to the **emergency room** because of breathing problems or asthma?

C. Gone to the **clinic** because of breathing problems or asthma?

11. How many days of school have you missed **this school year** because of asthma or breathing problems?

- 0 days
- 1 – 2 days
- 3 – 5 days
- 6 – 9 days
- 10 – 14 days
- 15 or more days

Form reviewed and/or discussed with student. _____
Signature of LSN _____ Date _____

Thank You!

For office use only:	<u>Student Symptom Severity assessment:</u>
1 B. _____	Mi. _____
	Mi. P. _____
1 D. _____	Mo.P. _____
	S.P. _____

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Student Breathing/Asthma Questionnaire (SBQ) Instructions

Purpose:

- The licensed school nurse uses the Student Breathing Questionnaire (SBQ) to:
 - determine if the student's asthma is under control.
 - develop an appropriate plan of care (IHP) if appropriate.
 - determine asthma severity level.

Instructions:

- The health service assistant (HSA), licensed practical nurse (LPN), and/or licensed school nurse (LSN) will administer the SBQ to any student in Grades 6 – 12 with asthma:
 - on initial visit to the Health Office during the school year.
 - who frequently presents with asthma symptoms.
 - who takes medication on a routine basis.
 - who is reported to the Health Office staff as absent due to asthma \geq 1 day.
 - per request of the LSN.
- If the student's asthma status appears to be changing, the LSN can repeat the SBQ if indicated (moderate to severe asthma, out-of-control asthma).
- Assist student with SBQ if student cannot read at 3rd grade level or needs interpreter services.

Documentation:

- Document administration on daily log.
- Summarize findings in narrative notes of the Pupil Health Record (LSN).
- File in the Pupil Health Record (LSN).
- Document Severity Level on SHOAR and computerized health problem list (LSN).

Student Breathing Questionnaire (SBQ) Asthma Severity Rating Instructions

- 1) Score questions 1B. and 1D. as follows:

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Find the Severity Assessment box at the bottom of the form (see sample below)

<u>For office use only: Student Symptom</u>	
<u>everity</u>	
<u>assessment:</u>	
1 B. _____	Mi. _____
	Mi. P. _____
1 D. _____	Mo.P. _____
	S.P. _____

- 2) For 1B., under frequency of symptoms, score as follows:
- if the 1st box is checked, write M.I. after 1B. _____ in the “For Office Use Only” box
 - if the 2nd box is checked, write Mi.P after 1B. _____ in the “For Office Use Only” box
 - if the 3rd box if checked, write Mo.P. after 1B. _____ in the “For Office Use Only” box
 - if the 4th box is checked, write S.P. after 1B. _____ in the “For Office Use Only” box
- 3) For 1D., score as follows:
- if the 1st box is checked, write M.I. after 1D. _____ in the “For Office Use Only” box
 - if the 2nd box is checked, write Mi.P after 1D. _____ in the “For Office Use Only” box
 - if the 3rd box if checked, write Mo.P. after 1D. _____ in the “For Office Use Only” box
 - if the 4th box is checked, write S.P. after 1D. _____ in the “For Office Use Only” box
- 4) Look at the severity assessment for 1B. _____ and 1D. _____ and choose the more severe of the two assessments. For example, if the score for 1B. Was Mi.P. and the score for 1D. Was Mo.P., you would estimate that according to the child’s symptoms, he/she currently has symptoms consistent with Moderate Persistent Asthma. Check the severity assessment line to indicate the student’s asthma severity.

Asthma Individual Health Plan

Student _____ **Student ID#** _____ **Birthdate** _____

School _____ **Grade/Room** _____

Parent/Guardian _____ **Phone** _____

Primary Care Provider _____ **Phone** _____

Assessment Data: (check or circle if applicable)

Signs/symptoms	Triggers	Attendance Issues	Student's Strengths
<input type="checkbox"/> wheezing <input type="checkbox"/> difficulty breathing <input type="checkbox"/> chest tightness <input type="checkbox"/> cough <input type="checkbox"/> other (describe): _____ _____ _____	<input type="checkbox"/> exercise <input type="checkbox"/> cold air <input type="checkbox"/> dust <input type="checkbox"/> stress <input type="checkbox"/> infection <input type="checkbox"/> allergies (describe): _____ _____ _____	<input type="checkbox"/> chalk/markers <input type="checkbox"/> perfumes <input type="checkbox"/> smoke <input type="checkbox"/> air fresheners <input type="checkbox"/> animals (describe):: _____ _____ _____	Y/N school Y/N physical ed. Y/N classroom Y/N recess <input type="checkbox"/> has developed age appropriate self management skills <input type="checkbox"/> good problem solving ability <input type="checkbox"/> communicates needs <input type="checkbox"/> accepts diagnosis <input type="checkbox"/> effective coping skills <input type="checkbox"/> good social skills <input type="checkbox"/> other _____ _____

Predicted peak flow _____	Frequency of asthma episodes _____	Has positive support system
Personal best peak flow _____	Number of hospitalizations _____	Yes No
	(in the last 12 months)	Describe _____

Family Resources:

- | | |
|---|---|
| 1. Has phone: Y / N/ Sometimes | 4. Has transportation: Y / N/ Sometimes |
| 2. Utilizes primary clinic: Y / N/ Sometimes | 5. Receives preventive care: Y / N/ Sometimes |
| 3. Utilizes community resources: Y / N/ Sometimes | 6. Housing meets family needs Y/ N/ Sometimes |

Comments

Current medications: home (h) and school (s), including OTC and alternative meds

Name	Route	Dose	Frequency

IEP: Y/N Primary disability _____ Receiving special education nursing services: Y/N D(min) _____ Ind(min) _____
 Adaptations: Asthma needs noted Y/N (attach)

504 Plan: Y/N (attach)

<p>Nursing Diagnosis:</p> <ol style="list-style-type: none"> Potential for alteration in respiratory function. Potential for less than optimal school achievement due to asthma. Other (describe) _____. 	<p>Goals:</p> <ol style="list-style-type: none"> Increase knowledge &/or skills related to asthma to maintain near normal pulmonary function. Participate in regular school/class activities, including physical education class, with modifications made as necessary. Other (describe) _____.
--	---

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Interventions: (Check if applicable)

First Aid ___ loosen clothing ___ encourage relaxation ___ encourage pursed lip breathing
___ use peak flow meter ___ administer medication
___ administer room temperature fluids by mouth if able to swallow
___ other _____

Referral/s (to clinic, home care, other community agency,etc.) _____

Parent /Guardian action/education _____

Asthma Education/Self Management Skills (Education code *- see below)

	Date	Date	Date	Date	Date		Date	Date	Date	Date	Date
What is asthma?						Correct peak flow meter techniques					
AAP – knows zones and action						Knowledge of Triggers					
S/S, warning signs						Environmental control					
Correct inhaler technique						Techniques for staying active					
Correct neb technique						Medication Review					

*Document date, education code U/N and initials for each encounter (U=understands N=needs more information)

Comments/Progress toward goals:

Empty box for comments and progress toward goals.

Student Out Comes:

1. Student will participate in classroom/school activities with modifications as needed.
2. Student will improve or maintain understanding of checked items under Asthma Education/Self Management Skills.
3. Other (describe) _____

Plan initiated: Date: _____ LSN Signature _____

Date: _____ Parent /Guardian Signature _____

Date: _____ Student Signature _____

Plan reviewed: Date: _____ LSN Signature _____

Date: _____ LSN Signature _____

Date: _____ LSN Signature _____

Asthma Emergency Care Plan

Student Name: _____ Date: _____
 Birthdate: _____ SS#: _____ Grade/Room: _____
 Parent's Name: _____ Phone: (____) _____
 Emergency Contact: _____ Phone: (____) _____
 Emergency Contact: _____ Phone: (____) _____
 Health Care Provider: _____ Phone: (____) _____
 Hospital In Case Of Emergency: _____

Asthma History: _____

Symptoms (If you see this)	Actions To Take (Do this)
<ul style="list-style-type: none"> ❖ Breathing trouble <ul style="list-style-type: none"> • Unusually fast or slow breathing • Breaths unusually deep or shallow • Gasping for breath, wheezing or coughing • Person feels short of breath ❖ Difficulty talking or walking ❖ Tightness in chest, upset stomach, restless, anxious ❖ Blue or gray discoloration or lips for fingernails ❖ Other _____ 	<ul style="list-style-type: none"> ❖ Remain calm. Reassure and stay with student. ❖ Give medication <ul style="list-style-type: none"> Name: _____ Route: Inhaler/Neb Dose: _____ Frequency: _____ Location of med: _____ ❖ Notify school health office. ❖ Have student sit up and breathe evenly, breathing through nose, and breathing out with pursed lips. ❖ Give room temperature water to sip. ❖ Elevate arms to shoulder level and provide support for arms (desk or back of chair). ❖ Notify parent/guardian/emergency contact. ❖ Other _____

Call 911

- ❖ If no improvement 5-10 minutes after using medication OR if no medication available.
- ❖ If worsening breathing symptoms
 - Chest and neck pulled in with breathing
 - Child is struggling to breathe
 - Trouble walking or talking
 - Lips or fingernails are gray or blue
 - Increasing anxiety, confusion

Signatures:

Parent/Guardian _____

School Nurse _____

Date to be reviewed: _____

cc: Parent, Teachers, Phy Ed Teacher, Transportation, Other _____

Prevention Strategies: (Check if applicable)	Copy given to / date	Copy given to / date
____ Teacher information given (date) _____	_____	_____
____ Cover nose and mouth in cold weather	_____	_____
____ Use inhaler before exercise	_____	_____
____ Avoid contact with animals in classroom	_____	_____
____ Avoid known allergens (list) _____	_____	_____
____ Student to take controller medications daily	_____	_____
____ Other _____	_____	_____
_____	_____	_____

Self –Administration of Asthma Medication Authorization Procedure

When a health care provider, parent/guardian, student and school nurse agree that self-administration of asthma or other medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately.

The attached form must be completed by the prescribing health professional and parent/guardian and returned to the school nurse. Orders must be renewed annually or whenever medication, dosage, or administration changes.

The parent / guardian / family must provide to the school health office:

- a written order by a health care provider (could be in the form of a signed AAP, medication consent form, OR this self-administration form)
- a written authorization by the parent/guardian (could be in the form of a signed AAP, medication consent form, parent questionnaire, OR this self-administration form)
- the inhaler and/or other medication in a container appropriately labeled by a pharmacist or the health care provider

The student will need to:

- complete a student breathing questionnaire (SBQ)
- demonstrate competency in taking his/her medication safely
- demonstrate appropriate asthma management and self-care skills
- appropriately complete and sign the agreement that accompanies this form
- follow-up as indicated on the agreement

The licensed school nurse will need to:

- determine asthma severity level from the SBQ if not indicated on an AAP, and assess level of asthma control
- assure the student understands what is asthma, early and late warning signs / symptoms, peak flow usage as appropriate, what to do to prevent and relieve symptoms, the concept of good control, asthma management steps, how to use their asthma action plan, the difference between controller and reliever medication, appropriate self-care skills, and can demonstrate appropriate medication technique / competency (including knowing how to tell time and decide when to take their medications). If you have doubts about a student's understanding, you may want to consider initiating a home care visit for asthma education (see asthma care coordination resource list).
- for older students, in preparation for currently (or in the future) being able to self-manage their own disease, assess whether they know / understand
 - who their primary health care provider is
 - The importance of choosing and building a relationship with one health care provider
 - how to make their own asthma appointments (and when)
 - the need for preventive "Well Asthma Care" at least every 6 months
 - where their pharmacy is
 - how to fill and refill their own prescriptions
- Intervene on the student's behalf by communicating with the student's parent/guardian and health care provider as needed in order to promote better asthma control and acquisition of asthma self-care skills.

Student Agreement

I agree to:

- use correct inhaler technique (demonstrate to nurse)
- not allow anyone else to use my medication
- maintain a written record of my medication administration at school (e.g. in my planner, notebook, etc.)
- keep a current supply of my medication located (e.g. purse, backpack, etc.) _____
- keep spare medication in the nurse's office
- check-in with the school nurse __daily __weekly __monthly __other : _____
(note what day of the week and time _____)
- notify the school nurse or _____ under the following circumstances;
_____ I need to take my quick-relief medication (albuterol) more often than 2 x a week during the day or more than 2 x a month at night
_____ I have asthma symptoms after exercise, sports or physical education class
_____ My symptoms don't go away or get worse after taking my medication
_____ I suspect that I am having side effects from my medication
_____ My peak flow reading or symptoms is/are in the yellow or red zone
_____ Other _____
- follow my health care provider's orders
- refill my prescriptions before they run out (or help remind my parent/guardian to do so)
- see my health care provider for preventive "Well Asthma Check-ups" at least twice a year
- call my health care provider if I am having symptoms that don't get better after a day or so

I know or will find out:

- who my health care provider is and how to contact her / him
- where my pharmacy is and how to contact

Signature of Student

Date

To Be Completed By Licensed School Nurse

- This student has demonstrated mastery related to his / her asthma medication and self-care skills.
- This student needs reinforcement of his/ her asthma medication and self-care skills.
- This student may self-carry and should check in with me as described above.
- _____

Signature of Licensed School Nurse

Date

NOTE: If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider to attempt to agree upon a plan. In the event agreement is not reached, the parents may refer the case to the Nursing Service Manager at _____ for resolution. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Nursing Service Manager for resolution.

Date _____

Dear Parent / guardian of _____,

Health staff in _____ schools encourage students to learn how to manage their asthma so that they can fully participate in school and sports and live a normal healthy life. Many students, especially in high school (and sometimes middle school), carry their asthma quick-relief inhaler with them.

Your child can carry his or her asthma quick-relief inhaler with him or her at school once the school health office receives:

- written consent from you
- written consent from his or her health care provider
- assessment and approval by the licensed school nurse

Written consents are needed every year and can come in the form of:

- an Asthma Action Plan signed by both you and the health care provider (preferred), or
- the attached form

Please make an appointment with your child’s health care provider for a Well-Asthma

Check-up. Your child should have this type of asthma check up at least twice a year. If your child doesn’t have a primary health care provider or asthma specialist at a clinic or office, please choose someone and try to always make an appointment with that person.

Ask your child’s health care provider to fill out an Asthma Action Plan or the attached form. Please fax it, or bring it to the school health office at your child’s school.

The school nurse will meet with your child to assess his or her asthma skills and determine a plan for him or her to carry his/her medicine at school.

Thank you!

Health Assistant or LPN

Phone number

LS N/RN/PHN

Pager number

Fax number

Parent's Permit And Health Questionnaire

This form must be completed, signed and returned to the school each year before the student will be permitted to practice or play.

Name of student _____ Birth date _____
Type or print Month Day Year

High School _____ Grade in School 7 8 9 10 11 12
Circle one

Minnesota State High School League regulations provide that any student who intends to participate in high school interscholastic athletics and cheerleading activities must have on file in this school a record of satisfactory physical examination performed by a doctor within the previous three years. More frequent examinations may be required.

The following questions *must* be answered by the parent or guardian: Please Circle

- | | | |
|--|-----|----|
| Does the student named above have a physical exam form on file in the school? | Yes | No |
| Has the student been hospitalized since the above physical examination? | Yes | No |
| Has the student had a major injury since the above physical examination? | Yes | No |
| Has the student been found to have only one organ of usually paired organs?
(example: only one kidney, or one good eye) | Yes | No |
| Has the student ever been diagnosed by a doctor as having asthma? | Yes | No |
| Has the student had episode(s) of wheezing (whistling in the chest) in the last 12 months? | Yes | No |
| In the last 12 months, has the student wheezed or coughed after activity, exercise or sports? | Yes | No |
| Does the student have diabetes? | Yes | No |
| Does the student have seizures? | Yes | No |
| Does the student have a severe allergy that could result in a life-threatening emergency?
(List Allergy/Allergies) _____ Epi-pen required? | Yes | No |
| Does the student take medication on a daily or as needed basis?
(example: insulin or a daily asthma "controller", or as needed asthma "reliever" medication) | Yes | No |
| Has the student been knocked unconscious, had a concussion, or had a head injury at any time within the past 12 months? | Yes | No |
| Has the student fainted, blacked out, experienced dizziness or chest pain while exercising in the last year? | Yes | No |
| Are there any weight loss or nutritional issues to consider, including self-induced vomiting, over-exercising, laxative use, or diuretic use to control weight? | Yes | No |
| Do you know or believe there is any health reason why this student should not participate in interscholastic athletics or other school activities? If so, why? _____ | Yes | No |

In the last year:

What was the student's lowest weight? _____
 What was the student's highest weight? _____
 What do you think is his/her ideal weight? _____

Athletic Insurance Information

I understand the following:

1. There is *no coverage* by the Public Schools for insurance or benefit plans for student athletes.
2. There is a risk of injury, including catastrophic injury, while participating in high school athletics.
3. The Catastrophic Plan by the Minnesota State High School League is in effect for injury costs over \$25,000.00.
4. It is recommended that all parents have some type of hospitalization and medical coverage.

This Parent's Permit and Health Questionnaire must be completed, signed and placed on file in the school office each year before the student will be permitted to practice or play.

Sport:	Fall	Winter	Spring	Name _____ Student I.D. _____ Date of Birth _____
--------	------	--------	--------	---

**Predicted Pediatric Guide to
Peak Flow Zones for Providers
(Revised September 2000)**

Height	Predicted Peak Flow	Green Zone (100-80%)	Yellow Zone (79-50%)	Red Zone (Below 50%)
43"	147	150 – 119	118 – 74	<74
44"	160	160 – 128	127 – 80	<80
45"	173	175 – 139	138 – 87	<87
46"	187	190 – 150	149 – 94	<94
47"	200	200 – 160	159 – 100	<100
48"	214	215 – 171	170 – 107	<107
49"	227	230 – 182	181 – 114	<114
50"	240	240 – 192	191 – 120	<120
51"	254	255 – 203	202 – 127	<127
52"	267	270 – 214	213 – 134	<134
53"	280	280 – 224	223 – 140	<140
54"	293	295 – 234	233 – 147	<147
55"	307	310 – 246	245 – 154	<154
56"	320	320 – 256	255 – 160	<160
57"	334	335 – 267	266 – 167	<167
58"	347	350 – 278	277 – 174	<174
59"	360	360 – 288	287 – 180	<180
60"	373	375 – 298	297 – 187	<187
61"	387	390 – 310	309 – 194	<194
62"	400	400 – 320	319 – 200	<200
63"	413	415 – 330	329 – 207	<207
64"	427	430 – 342	341 – 214	<214
65"	440	440 – 352	351 – 220	<220
66"	454	455 – 363	362 – 227	<227
67"	468	470 – 374	373 – 234	<234
68"	482	485 – 385	384 – 241	<241
69"	498	495 – 398	397 – 249	<249
70"	510	510 – 408	407 – 255	<255
71"	525	525 – 420	419 – 262	<262
72"	539	540 – 431	430 – 269	<269



Asthma Update

Green Zone

Breathing is easy; no cough; can work and play without symptoms.

For gym or recess:

Slow gradual warm up, then
may participate fully in gym or recess.

Return to health office if problems with breathing, coughing or wheezing.

Student name _____ Date / Time _____

Asthma Update

Green Zone

Breathing is easy; no cough; can work and play without symptoms.

For gym or recess:

Slow gradual warm up, then
may participate fully in gym or recess.

Return to health office if problems with breathing, coughing or wheezing.

Student name _____ Date / Time _____

Asthma Alert

Yellow Zone

Cough, wheeze, tight chest, difficulty breathing, and/or trouble sleeping

Restricted activity for gym or recess:

- Slow gradual warm up
- No strenuous activity
- Activity only as tolerated

Return to health office if problems with breathing, coughing or wheezing

Student name _____ Date / Time _____

Asthma Alert

Yellow Zone

Cough, wheeze, tight chest, difficulty breathing, and/or trouble sleeping

Restricted activity for gym or recess:

- Slow gradual warm up
- No strenuous activity
- Activity only as tolerated

Return to health office if problems with breathing, coughing or wheezing

Student name _____ Date / Time _____

Permanent Health Office Pass

Name _____ Grade _____

When to be used:

- Before Physical Education Class
- Before Recess
- At _____ AM daily
- At _____ PM daily
- Any time student has breathing difficulty, coughing, wheezing, tight chest or other \ symptoms

Date Issued: _____

Good for / until:

- Entire _____ School Year
- _____ (End date)

Issued by: _____

Title: _____

Lung Auscultation/Respiratory

Skill Validation Tool For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Lung Auscultation/Respiratory Assessment	Yes	No
1. Describe when auscultation of lungs is indicated: ▪ when student presents with symptoms (and LSN or LPN is present).		
2. Describe purpose of auscultation		
a. to check quality of air exchange		
b. to assess symptoms and severity of asthma episode		
3. Describe location of underlying lungs and their lobes in relation to chest wall (see diagram on back).		
a. Apex of each lung rises 2-4 cm above inner third of clavicle (Anterior)		
b. Inferior border crosses the 6 th rib at midclavicular line (Anterior)		
c. Apex of each lung above scapulas (Posterior)		
d. Lower border is at level of 10 th thoracic spinous process. (Posterior)		
4. Describe breath sounds		
a. Crackles: • Coarse Crackle: discontinuous, interrupted explosive sounds, loud, low in pitch (heard when air passes through larger airways containing liquid). • Fine Crackle: discontinuous, interrupted explosive sounds, less loud and of shorter duration; higher in pitch than coarse crackles (heard when air passes through smaller airways containing liquid).		
b. Wheeze: continuous sounds, high pitched; a hissing sound (airway narrowed by asthma or partially obstructed by tumor or foreign body).		
c. Rhonchus: continuous sounds, low-pitched; a snoring sound (caused by large upper airway partially obstructed by thick secretions).		
5. Describe how to assess severity of asthma episode with regard to Inspiration/Expiration Ratio, Wheezing and Retractions. ¹		
a. Inspiration/Expiration Ratio • Normal: inspiration takes twice as long as expiration • Mild: hardly a difference between inspiration and expiration. • Moderate: Inspiration is equal to expiration • Severe: Expiration is longer than inspiration		
b. Wheezing • Mild: wheezing noted at end of expiration • Moderate: wheezing throughout expiratory phase. Eventually wheezing is noted on inspiration also. • Severe: wheezing is not apparent because the bronchial tubes are so constricted that air exchange is blocked.		
c. Retractions ▪ Mild: retractions are not present ▪ Moderate: very mild retractions, if any, are noted. ▪ Severe: retractions are indicative of a severe episode. In some cases, the skin in between the ribs gets drawn in when the child inhales.		
6. Demonstrates procedure for auscultation		
a. demonstrates position of student when assessing lung status (sitting or standing)		
b. location and sequence of auscultation. Compare symmetrical areas of the lungs from above down. Be alert for student discomfort secondary to hyperventilation and allow rest as needed.		
c. with stethoscope, listen to lungs as student breathes through his mouth more deeply than normal		
d. listen at least one full breath in each location.		

¹ Reprinted from *AIR CURRENTS*; Volume 1, No. 5: September, 1990

7. Describes components of Physical Respiratory Inspection.		
a. Respiratory rate: 4 years: 23/min; 6 years: 21; 8 years: 20; 10 – 14 years: 19; 16 years: 17; 18 years: 16 to 18.		
b. Rhythm: (regular, irregular or periodic)		
c. Depth (deep or shallow)		
d. Quality (effortless, automatic, difficult, or labored)		
e. Character (noisy, grunting, snoring, or heavy)		
8. Documents findings on appropriate record including location of abnormal breath sounds (anterior, posterior, right upper lobe, right lower lobe, left upper lobe, left lower lobe): <ul style="list-style-type: none"> ▪ AVN ▪ SHOAR ▪ AMR (if indicated) 		

Demonstrated Competency Yes No

Metered Dose Inhalers/Spacers

Skill Validation Tool
For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Metered Dose Inhalers/Spacers	Yes	No
1. Describe the benefits of a metered dose inhaler (MDI).		
a. quick		
b. portable		
c. direct delivery to lungs		
2. Advantages of using a spacing device with the MDI (higher percent of dose reaches the lung).		
3. Using the MDI with a spacer		
a. stand up		
b. shake well to mix medicine (5 seconds)		
c. remove caps from both inhaler and spacer (check that there is nothing in the mouthpiece or spacer that could be accidentally inhaled). Attach spacer to inhaler.		
d. hold inhaler upright		
e. breathe out gently, get as much air out of the lungs without forcing		
f. close lips around mouthpiece while tilting head back slightly		
g. press down on inhaler while breathing in slowly and deeply (3-5 seconds) to fill lungs completely		
h. hold breath for as long as possible (10 seconds) and then exhale		
i. wait 1 minute before each puff or as prescribed by primary provider		
4. Special inhalers/spacers/holding chambers		
a. InspirEase spacer: has special feature to help teach better breathing technique, and is very useful for use with students who don't fully understand how to breathe in and out, or are not able to hold their breath.		
i. Connect mouthpiece to the resevier bag by lining up the locking tabs with the opening in the bag, then push in and twist to lock.		
ii. Untwist the bag gently to open it to its full size. Remove inhaler canister from it's original plastic "boot" and shake well before placing its stem in the mouthpiece (some canisters may fit more loosely than others which will not affect drug delivery).		
iii. If desired, place the clear cylinder-like piece – the actuation aid – over the inhaler canister, fitting grooves into matching slots in the mouthpiece. This allows the student to use both hands to dispense the medication in stead of just one hand.		
iv. Place mouthpiece in mouth and close lips tightly around it.		
v. Place fingers on fingerholds with thumb under mouthpiece and pull down with fingers to release one dose of medicine into the bag.		
vi. Breathe in slowly through the mouthpiece. If you hear a whistling sound, breathe slower until no sound can be heard.		
vii. Breathe in the entire contents of the bag until the bag collapses and student can't breather in anymore.		
viii. Hold breath while slowly counting to 5 (or 10).		
ix. Breathe out slowly into the bag.		
x. Repeat the breathing in and out steps (vi. – ix.) a second time, keeping lips tightly closed around the mouthpiece.		
b. Valved holding chamber (e.g aerochamber, optichamber, etc.). Follow the same instructions as the MDI with spacer directions above. Be aware that with these types of chambers, if student breathes in too fast, a whistling sound will be heard).		
c. Azmacort (white corticosteroid inhaler which comes with a built-in spacer)		
i. Pull open the white canister so that it is about twice as long as it was in it's collapsed state. Then bend the inhaler into an "L" appearance.		
ii. Remove cap, shake inhaler and use as you would a regular MDI with spacer.		

5. Describe how to clean the spacer and MDI each week		
a. Look at the hole where the medicine sprays out from your inhaler. If you see "powder" in or around the hole, clean the inhaler.		
b. To do so, remove the metal canister from the L-shaped plastic mouthpiece.		
c. Rinse only the mouthpiece and cap in warm water (on daily basis).		
d. Let plastic pieces dry overnight		
e. In general, clean spacers once a week or according to manufacturer's instructions (to prevent build-up of medication on the sides & mouthpiece).		
f. Take spacer apart and wash each piece separately. Some spacers have delicate flap valve, the soft, round disk under the mouthpiece. Remove, do not rip disk. Replace if disk begins to harden and curl.		
g. Use warm water and a gently soap or gentle dishwashing detergent.		
h. Let pieces air-dry on a clean lint-free towel before using spacer again.		
i. With bag type spacers such as InspirEase, the collapsible bags should not be washed; they are disposable if they tear. The length of time between bag replacements varies by manufacturer. Check manufacturer's instructions. Wipe mouthpiece of bag type spacers after each use.		
6. To determine the number of puffs left in the inhaler (# of puffs listed on canister) Divide total # by # of puffs taken/day and subtract from total # to determine # of puffs left in canister.		
7. Document the MDI treatment in the appropriate record (SHOAR) as well as cleaning (in comments section or elsewhere on form)		
8. Document education provided and meds given to student in the appropriate record (SHOAR)		

Demonstrated Competency

Yes

No

Dry Powder Inhalers

Skill Validation Tool For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Dry Powder Inhalers	Yes	No
1. Describe the benefits of using a dry powder inhaler		
a. no spacer required		
b. has counter to determine amount of medication left or indicator that medication is running out.		
c. better disposition of medication		
2. Describe difference between MDI and DPI inhalers		
a. MDI is aerosolized, DPI is dry powder		
b. with DPI can inhale as many times as needed to take complete dose		
3. How to use Turbuhaler		
a. stand up straight		
b. If using for the first time, prime the inhaler (twist brown grip fully to the right and back again to the left – do this twice)		
c. load dose: twist cover and lift off, hold turbuhaler upright, twist the brown grip fully to the right. Twist it back again fully to the left. It will click		
d. Turn head away from inhaler and breathe out (never exhale into inhaler)		
e. place the mouthpiece between lips and inhale forcefully and deeply, holding turbuhaler upright (mouthpiece up) or horizontal		
f. place cover back on the inhaler and twist shut. Rinse mouth with water. Do not swallow		
g. keep turbuhaler clean and dry at all times		
4. Determine how much medication is left in inhaler		
5. How to use Diskus (Serevent/Advair)		
a. hold Diskus in one hand and put the thumb of your other hand on the thumbgrip. Push thumb away from you until mouthpiece appears and snaps into position.		
b. hold Diskus in level horizontal position and slide the lever away from you until it clicks		
c. holding the Diskus level and away from mouth, breathe out as far as possible (never breathe out into the Diskus)		
d. put the mouthpiece to lips. Breathe in steadily and deeply		
e. remove Diskus from mouth, hold breath for 10 seconds, breathe out slowly		
f. to close Diskus, put thumb on the thumbgrip and slide the thumbgrip back towards you as far as it will go until it clicks shut.		
6. How to use Aerolizer Inhaler (Foradil)		
a. Pull off the Aerolizer Inhaler cover.		
b. Hold the base of the Aerolizer Inhaler firmly and twist the mouthpiece in the direction of the arrow to open. Push the buttons in to make sure that the 4 pins are visible in the capsule well on each side.		
c. Remove capsule from foil blister immediately before use. Peel paper backing from blister and push capsule through the remaining foil.		
d. Place capsule in the capsule-chamber in the base of the Aerolizer Inhaler. <i>Never place a capsule directly into the mouthpiece.</i>		
e. Twist the mouthpiece back to the closed position.		
f. With the mouthpiece of the Aerolizer Inhaler upright, simultaneously press both buttons once . You should hear a click as the capsule is being pierced.		
g. Release the buttons. If the buttons stick in the depressed position, grasp the wings on the buttons to retract them before the inhalation step. Do not depress the buttons a second time, since in rare cases this may cause the capsule to shatter into small pieces. These pieces should be retained by the screen built into the Aerolizer Inhaler.		

h. Exhale fully. Do not exhale into the mouthpiece!		
i. Tilt your head back slightly. Keeping the Aerolizer Inhaler horizontal, with the blue buttons to the left and right (NOT up and down), place the mouthpiece in your mouth, closing your lips around the mouthpiece.		
j. Breathe in rapidly but steadily, as deeply as you can. As the capsule spins around in the chamber dispensing the placebo powder, you will experience a sweet taste and hear a whirring noise. If you have not heard the whirring noise, the capsule may be stuck. If this occurs, open the Aerolizer Inhaler and loosen the capsule allowing it to spin freely. Do not try to loosen the capsule by repeatedly pressing the buttons.		
k. While removing the Aerolizer Inhaler from your mouth, continue to hold your breath as long as comfortably possible, then exhale.		
l. Open the Aerolizer Inhaler to see if any powder is still in the capsule. If any powder remains repeat steps h – k. Most people are able to empty the capsule in one or two inhalations.		
m. After use, open the Aerolizer inhaler, remove and discard the empty capsule. Do not leave a used capsule in the chamber. Close mouthpiece and replace the cover. Keep the Aerolizer Inhaler and foradil capsules in a dry place. Never wash the inhaler. Use the new one that comes with each refill.		
7. Document treatment and education		

Demonstrated Competency

Yes

No

Maxair Inhaler
Skill Validation Tool
For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Maxair Inhaler	Yes	No
1. Describe the benefits of a Maxair inhaler		
a. do not need spacer		
b. very portable		
c. breath-activated: automatically releases a precisely measured puff of medicine when you inhale.		
d. Pirbuterol last up to 6 hours compared to 4 hours for Albuterol.		
e. each inhaler has 300 puffs rather than usual 200 for MDI inhalers		
2. Using the Maxair inhaler		
a. stand up		
b. locate the up arrows on the autohaler and the air vents at the bottom of the inhaler		
c. take off cap		
d. hold the inhaler upright and keep it that way until after use		
d. push red lever up so that it stays up		
e. hold the inhaler around the middle and shake it several times		
f. exhale completely		
g. seal lips tightly around mouthpiece		
h. inhale deeply through the mouthpiece with steady force		
i. you will hear a click and feel a puff of medicine. Do not stop inhaling until you have taken a full deep breath		
j. hold breath for 10 seconds and then exhale		
k. when finished, lower the lever while holding the inhaler upright		
l. wait one minute between puffs		
m. repeat procedure for second puff		
3. Describe how to clean inhaler		
a. Remove mouthpiece cover by pulling down lip on back of cover.		
b. Gently tap back of autohaler so flap come down and spray hole can be seen. With white flap down, clean the surface of the flap with a dry cotton swab.		
c. Turn autohaler upside down. Wipe mouthpiece with a clean dry cloth.		
4. Document the treatment and the education in the appropriate record		

Demonstrated Competency Yes No

Nebulizer Treatment

Skill Validation Tool
For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Nebulizer Treatment	Yes	No
1. Define mechanism and benefit of a nebulizer treatment		
a. aerosolizes medication for direct delivery to lungs		
b. can be used with students too young, too sick to use inhaler		
2. Set up nebulizer		
a. machine on level surface, off floor, away from table edge		
b. plug power cord into 3-prong outlet		
c. wash hands		
d. put prescribed amounts of medicines into neb cup		
e. add normal saline (if ordered)		
f. put top on the neb cup and attach appropriate mouthpieces		
g. connect air tubing to machine and neb cup		
3. Turn neb machine on		
4. Seal lips tightly around mouthpiece or put on mask		
5. Hold neb cup in upright position for the whole treatment		
6. Deep breaths through mouth (hold 1 – 2 seconds before breathing out if able) until all of the medicine is gone from the neb cup		
7. Describe how to clean the neb cup and attachments after each treatment		
a. after each use, rinse the mask, mouthpiece and neb cup (not the long tube) with warm water for 30 seconds. Dry on a clean paper or towel.		
b. once a week, place the parts (except the long tube) in a mixture of 1 part vinegar and 2 parts water. Soak them for at least 30 minutes. Rinse with warm water and dry on a clean towel.		
c. Replace the filter (on the machine) as advised or sooner if it becomes dirty.		
8. Document the treatment and the education in the appropriate record (SHOAR)		

Demonstrated Competency Yes No

Peak Flow Meter

Skill Validation Tool
For Health Office Staff

Name: _____ School: _____

Observed By: _____ Date Observed: _____

Peak Flow Meter	Yes	No
1. Describe the benefits of using a peak flow meter. (way to quantitatively measure lung function).		
2. Determine "personal best" peak flow measurement. "Personal Best" is the highest peak flow number a child can achieve over a 2 to 3 week period when his or her asthma is under good control.		
a. Always use the same peak flow meter		
b. Record Peak Flow 2 times/day for 2 weeks (morning and afternoon).		
c. A student's "Personal Best" is the established best peak flow reading over a 2 week period when student is healthy or in good control (do not rely on one outlying value which may be due to coughing or spitting into the peak flow meter).		
3. Determine predicted peak flow measurement.		
a. measure student's height		
b. Find height on peak flow guide to determine predicted peak flow		
4. Describe when to measure peak flow.		
a. on students with asthma symptoms		
b. to determine if medication is needed per AAP		
c. on students designated by LSN		
5. Describe the peak flow action zones.		
a. Green: (80 to 100 percent of your personal best) signals good control.		
b. Yellow: (50 to 79 percent of your personal best) signals caution: your asthma is getting worse.		
c. Red: (below 50 percent of your personal best) signals medical alert!		
6. Describe what actions to take to keep asthma under control in each zone.		
a. Green: Take your usual daily long-term-control medicines, if you take any. Keep taking these medicines even when you are in the yellow or red zones.		
b. Yellow: Add quick-relief medicines. You might need to increase other asthma medicines as directed by your doctor.		
c. Red: Add or increase quick-relief medicines and call you doctor now.		
7. Using a peak flow meter:		
a. stand up straight		
b. breathe in as much as possible		
c. close lips tightly around mouthpiece		
d. breathe out as fast and as hard as possible		
e. write down the number that the indicator moved to on the meter		
f. reset the indicator		
g. repeat steps a – f two more times		
h. record the highest number of three reading on PF graph		

8. Describe how to clean the PFM		
a. As needed, wash it inside and out with warm water and a mild liquid soap. Rinse. Shake out excess water and let it air dry before use. Health Office peak flow meters that are used on more than one student (using individual student mouthpieces with a filter) do not need to be cleaned after each use.		
b. Personal Best PF can be cleaned on the top rack only of dishwasher.		
9. Document PF in the appropriate record (SHOAR)		
10. Document education in the appropriate record (SHOAR)		

Demonstrated Competency Yes No

Model Pesticide Notice #1
General Notice for Parents or Guardians
July 26, 2000

Dear Parent or Guardian:

A Minnesota state law went into effect in year 2000 that requires schools to inform parents and guardians if they apply certain pesticides on school property.

Specifically, this law requires schools that apply these pesticides to maintain an estimated schedule of pesticide applications and to make the schedule available to parents and guardians for review or copying at each school office. [ALTHOUGH NOT REQUIRED BY THE LAW, SCHOOLS MAY CHOOSE TO INCLUDE A COPY OF THE ESTIMATED SCHEDULE OF PESTICIDE APPLICATIONS WITH THIS GENERAL NOTICE].

State law also requires that you be told that the long-term health effects on children from the application of such pesticides or the class of chemicals to which they belong may not be fully understood.

If you would like to be notified prior to pesticide applications made on days other than those specified in the estimated schedule (excluding emergency applications), please complete and return the form below and mail it to: [NAME, ADDRESS]. If you have any questions regarding this notice, please contact [NAME] at [PHONE].

Sincerely,

[NAME OF SCHOOL PRINCIPAL OR OTHER PERSON HAVING GENERAL CONTROL/SUPERVISION OF THE SCHOOL]

Request for Pesticide Notification

[NAME OF SCHOOL]

I understand that the school will make available an estimated schedule of pesticide applications for review and copying at the school office. Should a pesticide application be scheduled on a day different from the day(s) specified in the original schedule, I would like to be notified. I understand that the school may ask me for reimbursement for the costs of notification.

I would prefer to be notified by (circle): US Mail E-mail

Please print neatly:

Name of Parent/Guardian: _____ Date: _____

Address: _____

City, State, Zip: _____

Day Phone: (____) _____ Evening Phone: (____) _____ E-mail: _____

Return to:

[CONTACT NAME, ADDRESS]

Model Pesticide Notice #2
Individual Notice for Parent or Guardian
July 26, 2000

Dear Parent or Guardian:

At your request, we are writing to notify you about a pesticide application at [SCHOOL NAME]. Please see the information provided below. If you have questions regarding this notice, please contact [CONTACT NAME] at [PHONE].

Sincerely,

[NAME OF SCHOOL PRINCIPAL OR OTHER PERSON HAVING GENERAL CONTROL/SUPERVISION OF THE SCHOOL]

Notice of Pesticide Application

Date Form is Completed: _____

School Name: _____

Location of Planned Pesticide Application: _____

Pesticide Applied: _____

Planned Date/Time of Pesticide Application: _____

*[THE LAW DOES NOT SPECIFY WHAT IS REQUIRED TO DESCRIBE THE PESTICIDE BEING APPLIED. EXAMPLES OF WHAT THE SCHOOL MAY CHOOSE TO PROVIDE INCLUDE: THE NAME OF THE PESTICIDE PRODUCT, THE NAME OF THE ACTIVE INGREDIENTS, THE US ENVIRONMENTAL PROTECTION AGENCY (EPA) REGISTRATION NUMBER, ETC. BECAUSE PRODUCTS SHARE SIMILAR NAMES, THE MORE INFORMATION PROVIDED THE MORE LIKELY AN INTERESTED PARENT WILL BE ABLE TO DETERMINE WHAT WAS APPLIED. YOU MAY ALSO CHOOSE TO INCLUDE THE TYPE OF PEST TREATED AND/OR THE ORIGINAL DATE OF THE PLANNED PESTICIDE APPLICATION.]

Model Pesticide Notice #3
General Notice for School Employees
July 26, 2000

F34 

Dear School Employee:

A Minnesota state law went into effect in year 2000 that requires schools to inform school employees and parents if they apply certain pesticides on school property.

Specifically, this law requires schools that apply these pesticides to maintain an estimated schedule of pesticide applications and to make the schedule available to employees and parents for review or copying at the school office. [ALTHOUGH NOT REQUIRED BY THE LAW, SCHOOLS MAY CHOOSE TO INCLUDE A COPY OF THE ESTIMATED SCHEDULE OF PESTICIDE APPLICATIONS WITH THIS GENERAL NOTICE]

State law also requires that you be told that the long-term health effects on children from the application of such pesticides or the class of chemicals to which they belong may not be fully understood.

Sincerely,

[NAME OF SCHOOL PRINCIPAL OR OTHER PERSON HAVING GENERAL CONTROL/SUPERVISION OF THE SCHOOL]

[ALTHOUGH NOT REQUIRED BY LAW, SCHOOLS MAY CHOOSE TO PROVIDE INDIVIDUAL NOTIFICATION TO SCHOOL EMPLOYEES, UPON REQUEST, FOR APPLICATIONS MADE ON DAYS OTHER THAN THOSE SPECIFIED IN THE ESTIMATED SCHEDULE]