



# Teaching Staff and Educational Assistants

**A**nyone who works in a K-12 classroom has come in contact with students who have asthma. This chronic, but manageable, disease affects nearly 1 in 13 school-aged children.<sup>1</sup> What's more, in the past 15 years asthma in children has increased significantly in both numbers and severity.<sup>2</sup> It's the leading cause of hospitalizations among children.<sup>3</sup>

Asthma can be controlled with the right medications and modifications to environment. Because students spend a great deal of their day in school, teachers, assistants, paraprofessionals, volunteers and others who work in the classroom play an important role in helping students manage their asthma. Your knowledge and the steps you take can help ensure the immediate safety and long-term health of students under your care. You can create a supportive educational environment where all students can learn and thrive.

**“Healthy children learn better.”**

# Why Learning about Asthma is Important to Teaching Staff

## ASTHMA CAN BE DEADLY.

An asthma episode can escalate and may result in death without prompt medical attention.

## ASTHMA IS THE SINGLE MOST COMMON CHRONIC DISEASE CAUSING ABSENCE FROM SCHOOL.

Over 14 million school days are missed due to asthma each year.<sup>4</sup>

## ASTHMA CAN AFFECT A CHILD'S PERFORMANCE.

It can disrupt sleep, the ability to concentrate, memorize, and, when not managed properly can prevent a student from participating in normal school activities. Children who miss school due to uncontrolled asthma not only miss classroom instruction but they miss out on social interactions with other children which can lead to fears of social isolation, rejection and believing they are "different" from other children. A child who has asthma may feel drowsy or tired, anxious about taking medications, or even embarrassed when disruption to school activities occur due to an asthma episode.





# What Teaching Staff Need to Know

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## What is Asthma?

Asthma is a chronic disease that causes broncho-constriction (tightening of the muscles around the airways) and swelling of the airways. During normal breathing, air flows freely in and out of the lungs. But, during an “asthma episode,” linings of the airways (bronchioles) swell, muscles around the airways tighten and mucus clogs the tiny airways, making breathing difficult. The airways become overly responsive (twitchy) to environmental changes, sometimes resulting in wheezing, coughing, breathlessness, or tightness in the chest. During an asthma episode a child may feel he/she can’t inhale enough air, but actually, his/her lungs are having trouble exhaling.

Asthma symptoms can vary greatly from hour-to-hour and day-to-day. Symptoms are often worse at night and in the early morning hours. The severity of asthma varies from child to child and the severity may worsen or improve depending on the child’s symptom control and amount of exposure to triggers or allergens. Some children have occasional symptoms (e.g., after strenuous exercise), while others have symptoms that interfere with their daily life, including concentration and participating in school.

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## Recognizing the Signs of an Asthma Episode

Children themselves are often the best source for identifying an asthma episode. Children who have asthma often learn to identify their own unique early warning signs—the physical changes that occur as their airways begin to close. These early warning signs usually begin long before the more serious symptoms appear and taking action quickly is paramount to preventing an asthma crisis! An asthma episode is easier to subdue if a child and school staff are aware of significant changes and the child is able to take medication quickly.

There should not be any delay once a child has notified school staff of a possible problem or developing asthma episode.



During the initial phase of an asthma episode a child may exhibit one or more of these signs:

***Changes in breathing:*** Coughing, wheezing (a high pitched sound heard on exhalation), shortness of breath, breathing through the mouth, and or rapid breathing.

***Verbal complaints:*** Often a child who is familiar with their asthma symptoms will know that an episode is about to happen. The child may tell school staff that his/her chest is tight, or hurts, or that he/she cannot catch a breath. Complaints may include “dry mouth” or a more general “I don’t feel well” or “I’m scared.”

***Behavior changes and other signs:*** Clipped speech — a child may speak in very short, choppy sentences and appear to be gulping at air as he/she speaks. Some children may become very quiet (trying to control their breathing or simply out of fear) and subdued, while others may become highly agitated and panicky.

**To understand how an asthma episode feels, put a straw in your mouth and, while blocking off the nasal passages, quickly move around the room. The ability to pull enough air in through a narrowed passage causes sensations of desperation and panic. A straw can be removed and the airways restored immediately, but the child experiencing an asthma episode must wait for the airways to relax and if severe, for mucus to clear before they can breath easier. TIME IS OF THE ESSENCE!**

## What Causes Asthma Episodes?

Children with asthma have airways that narrow more easily than children who do not have asthma. They may be allergic or sensitive to inhaled (or even some ingested) irritants. A variety of factors can set off an asthma episode including viral infections (cold and flu season is especially difficult) and exposure to allergens or “triggers.” Each child with asthma reacts to a different set of factors.

### Some common “allergens” are:

- Dust mites
- Food\*
- Dander from furry or feathery animals
- Mold (*moist ceiling tiles or wet sink areas*)
- Seasonal pollens (*e.g., tree pollen in the spring, grass in the summer, ragweed in the fall*)
- Cockroach droppings
- Mice/rat dander, urine and their droppings
- Some medications (*e.g., aspirin*)

### Some common “triggers” are:

- Exercise (*Exercise induced asthma or EIA*)
- Cold air
- Chalk dust
- Viral/upper respiratory infections, bronchitis, sinusitis
- Strong emotional expressions (*such as stress, anxiety, anger, crying*)
- Air pollution—both indoor and outdoor
- Chemical irritants (*cleaning supplies, perfumes, whiteboard markers, paints, pesticides, glues*)
- Tobacco smoke, secondhand smoke, smoke from burning wood and other substances

**\*“About 6-8% of children who have asthma have food allergies that can trigger asthma symptoms.”<sup>5</sup>**



## PETS IN THE CLASSROOM

All warm-blooded animals can cause allergic reactions. Animal allergen is in dander, saliva, and urine. Allergen particles become airborne and accumulate in carpets, upholstery, and fabrics and on books, desks, and walls. Sensitive airways are affected by the odors from urine, cedar chips, room deodorizers, disinfectant sprays, and the flea powders or insecticides used to control fleas and ticks. Once furry animals are introduced into a school, removal does not immediately eliminate the exposure problem. A central ventilating system can contaminate the entire school. Even after a thorough cleaning, the allergens persist for months. Carpets in the room become a trap for animal dander and vacuuming just stirs up the particles. It is important to know what your school district policy is regarding animals in the schoolroom and to take into consideration children in the classroom who may have asthma or allergies.

## INDOOR AIR QUALITY

Indoor air quality or “IAQ” refers not only to the content of the air circulated throughout the school but also to the potential allergens and triggers that float around. Most people don’t consider a light spray of perfume or cologne as a potential irritant, but for some children, strong scents (chemicals, cleaning supplies, perfumes, paste, whiteboard markers etc.) are triggers that can aggravate an asthma episode. When possible, it’s best to avoid using items that have potential odor or scent producing irritants.

Mold is a problem that can be difficult to evaluate and remediate once in place. Moist environments promote mold (often called mildew) growth. It is important to keep drywall, carpeting, ceiling tiles, and even tiled floor areas as clean and dry as possible. If moisture sources or spills are found, they should be reported to the school custodian immediately so appropriate action can be taken to minimize mold growth. For more actions a teacher may take to maintain good indoor air quality (IAQ) visit the MDH Environmental Health page for teachers at: <http://www.health.state.mn.us/divs/eh/indoorair/schools/teachers.htm>

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## Exercise-Induced Asthma (EIA) and/or Exercise Induced Symptoms

Exercise is a very common trigger for asthma. However, since exercise and participating in sports are a part of healthy living, this is one trigger that should be managed and not avoided. For teenagers, exercise is often the most common cause of asthma symptoms. Some students may experience symptoms only when they exercise or participate in very strenuous activity (true EIA). Other students experience symptoms that are brought on by exercise, but they also may have an underlying persistent asthma that is exacerbated by the exercise. Students with underlying persistent asthma require controller medications whereas students with true EIA frequently do not. Any student who develops asthma-like symptoms should be referred to the Health Office for evaluation and possible referral to a health care provider. Fortunately, with better medications, monitoring and proper management, children can participate in physical activity and sports and achieve their highest performance levels!

## SYMPTOMS OF EIA AND/OR EXERCISE INDUCED SYMPTOMS

Symptoms may include coughing, wheezing, chest tightness and shortness of breath. Coughing is the most common symptom of EIA and may be the only symptom a child has at that time. The symptoms of EIA may begin during exercise and can be worse 5 to 10 minutes after stopping exercise or during the normal “cooling down” period rather than during the actual exercise. Symptoms can range from mild to severe and often resolve in 20 to 30 minutes. Occasionally, some individuals will experience “late phase” symptoms four to twelve hours after stopping exercise. These late phase symptoms are frequently less severe and can take up to 24 hours to go away. This is an important fact to remember when children are participating in school competitions that are repeated throughout the day.

## CAUSES OF EIA AND/OR EXERCISE INDUCED SYMPTOMS

When a child exercises, he/she breathes faster due to increased oxygen demands. Usually, during exercise a child inhales through the mouth, causing the air to be dryer and cooler than when breathing normally and through the nasal passages. Decreases in warmth and humidity are both causes of bronchospasm or “airway constriction.” Exercise that exposes a child to cold air like skiing, skating or hockey is therefore more likely to cause symptoms than exercise involving warm and humid air such as swimming. Pollution levels, high pollen counts and exposure to other irritants such as smoke and strong fumes can also make EIA symptoms worse. A recent cold or asthma episode can cause a child to have more difficulty exercising too.

***Do not leave a child having an asthma episode alone.***

## PREVENTING EIA

- ✓ Become familiar with the child’s asthma action plan and the symptoms of a pending asthma episode.
- ✓ Understand what to do if an asthma episode occurs during exercise and have the action plan or emergency care plan available for reference.
- ✓ If EIA is an issue with the child, check his/her asthma action plan or medical care plan for instructions. The most common preventive action is for the child use reliever medications 15 minutes prior to strenuous activity. If he/she does not carry an inhaler, the child will need to go to the school health office for medication administration.
- ✓ Warm up and cool down activities appropriate for any exercise will also help children with asthma. Give them time enough to slowly get their respiratory system warmed up.
- ✓ Permit less strenuous activities if the child has recently been ill or is having any sort of respiratory difficulty
- ✓ Refer your questions about a child’s ability to fully participate in physical activity to the school nurse for evaluation.
- ✓ Be aware of your district and school policies and procedures for administering medications.
- ✓ Check ozone/ air quality levels for outdoor activity prior to exercise outside. High pollen or high ozone levels can cause EIA in most children with asthma.
- ✓ Never encourage a child or athlete with asthma to “tough it out” and don’t allow other children to tease or encourage another who is wheezing to continue the activity.
- ✓ Respect the child’s right to confidentiality and privacy. Discussion and questions about how he/she feels (in detail) should be asked quietly and with discretion.
- ✓ Do not leave a child having an asthma episode alone. His/her ability to breathe needs to be watched for resolution or worsening.

## Asthma Medications



Treatment for asthma is based on how severe a child's symptoms are at any given time.

Typically, there are two types of medications used to treat asthma:

- Quick relief (reliever) or rescue, and
- Controller or preventive.

The most common asthma medications most school staff will come in contact with are the “*quick relief or reliever medications*” which are taken by inhalation.

### QUICK RELIEF (RELIEVER) OR “RESCUE”

These medications are taken when asthma symptoms flare up or a child is experiencing an “asthma episode.” They work fast to relieve symptoms as they happen, or to help prevent exercise-related symptoms. This is the medication you most frequently see a student use in an inhaler form when symptoms are flaring up or in the case of exercise-induced asthma (EIA) 15-30 minutes prior to strenuous physical activity. They relax the muscles surrounding the airways usually within 10-15 minutes after using the inhaler.

Typical brand names of these medications are: *Albuteral, Maxair, Proventil, Ventolin, Combiven and Alupent.*

It is important to remember that all medications carry the potential for side effects. Some common complaints with rescue medications include ***nervousness, jitteriness, nausea*** and, in some cases, ***drowsiness***. If side effects are excessive or the child is complaining of not feeling well, promptly contact the school nurse for evaluation and follow-up and do not leave the child unattended.

***A note about inhaled corticosteroids: When you hear the word “steroid” you might think of the steroids used by athletes. But inhaled corticosteroids are not the same steroids used by athletes and do not have the same side effects. They are the most consistently effective controller medications available.***

### LONG-TERM CONTROLLER OR “PREVENTIVE”

Some children require medications that are taken daily to prevent symptoms or episodes from developing. These are the controller or preventive medications. School staff may not see a child actually taking these medications, because children may only take them at home. It is important to understand that there is a difference between short acting reliever medications and long acting controller medications. These controller medications either reduce or prevent inflammation from occurring or in some cases, prevent symptoms by relaxing the muscles surrounding the bronchioles (airways) over a long period of time.

Typical controller medications are: *Advair, AeroBid, Azmacort, Beclovent, Flovent, PulmicortTurbuhaler, Pulmicort Respules Vanceril, Rotadisc, Accolate, Singulair, Zyflo, Filmta, Serevent, Foradil, Intal and Tilade.*

Oral (pills) corticosteroids are taken when an episode becomes severe, or when a child's asthma requires very intensive treatment.

### WHAT ARE THEY? HOW ARE THEY USED?

An asthma action plan (AAP) is an individualized tool that assists a caregiver in evaluating, monitoring and providing care to a child who has asthma. It is advisable for all children who have asthma to have a personalized AAP and or emergency care plan available at all times. While a teacher is not necessarily the person responsible to assess and care for a child who has asthma, it is essential they understand the process and tools available.

AAP's come in a number of different formats but the most common use the 3 color system: **green = go**, **yellow = caution** and **red = danger**." Under each color, there are measurements and instructions specific to that level of condition. When you match the symptoms (and Peak Flow, if available) to the correct color section and you'll find the steps to take.

A Peak Flow Meter (PFM) is a simple hand-held measurement tool used to determine if a child's ability to exhale air (true asthma) is lessening. Every child's peak flow (PF) is different but a dropping level indicates reduced breathing abilities. The school nurse may have a PFM for some children who have asthma. Talk to your school nurse for additional information.



#### **GREEN = GO**

Contains the controller medication the child takes everyday (if he/she does in fact require a daily medication.) It will also include instructions for medicating a child who has exercise induced asthma (EIA) prior to strenuous activity. The peak flow range for that child and the normal acceptable ranges can be included.

#### **YELLOW = CAUTION**

Gives the caregiver specific instructions for medications when the child is starting to have asthma symptoms. Instructions for how much and how often the child should receive rescue medication should be found here. A peak flow range will show a drop in numbers; typically 20% or more. The yellow zone is perhaps the most important because it gives the caregiver the opportunity to take action before symptoms become life threatening.

#### **RED = DANGER**

Means the child's symptoms have progressed to the point where emergency care is needed. A description of escalating symptoms and a PF that has dropped to below 50% indicates a child's lungs are filling with mucus and that the bronchial muscles are so contracted that the lungs cannot pull in air. Caregivers should call 911 immediately!

# What Teaching Staff Can Do

## Asthma Management - Working with the School Nurse

Most asthma episodes can be prevented through asthma management. Asthma management can be defined as “managing, preventing, treating and controlling factors (environmental, medications etc.) that affect a child’s asthma.” Proper asthma management requires collaboration and cooperation among all school personnel, the parent/guardian, medical provider and the child.

Asthma that is well managed at home can be thrown completely off track when a child is away from home. The school nurse is typically the driving force behind helping a child maintain good asthma care in school. But because children spend the majority of their day with in the classroom, teachers are usually the first adults to notice when a child’s asthma is flaring up. A teacher who is asthma “savvy” and who makes an effort to work with the school nurse, child and parent will find her student to be more cooperative, less likely to be fearful of having an asthma episode and more likely to achieve his/her own peak academic performance.



Provide prompt care for students who are having breathing difficulty.

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## Emergency Measures for Handling an Asthma Episode or Emergency

### Symptoms of breathing trouble:

- Unusually slow or fast breathing
- Breathes unusually deep or shallow
- Gasping for breath
- Wheezing, gurgling, high-pitched noises
- Skin unusually moist
- Skin flushed, pale, ashen/ bluish looking
- Person feels short of breath
- Person feels dizzy or light-headed
- Chest pain or tingling in hands or feet
- Person feels apprehensive or fearful
- Coughing
- Speaking in clipped or short bursts of speech
- Possibly restlessness or upset stomach

### Care of asthma and breathing trouble:

- Remain calm and reassure the child.
- Have the child sit up and breathe evenly, breathing in through nose, and breathing out with pursed lips.
- If an asthma episode is suspected, give a glass of room temperature water to sip.
- Elevate arms to shoulder level and provide support for the arms (*desk or back of chair*).
- Notify your health office nurse or responsible medical party.
- Give medication if ordered and available (*some students carry their asthma inhaler with them*).
- Contact parent/guardian.

### CALL 911 IF:

- Lips are blue or nail beds are blue -or-
- Child is having difficulty talking, walking or drinking -or-
- Quick relief or reliever medication (*inhaled reliever such as albuterol*) is ineffective, unavailable, or used too recently to repeat.-or-
- You see neck, throat, or chest retractions (*Sucking in of the skin between ribs or at base of the neck*) -or-
- There is nasal (*nares*) flaring when inhaling -or-
- Child is in obvious distress -or-
- There is an altered level of consciousness/confusion -or-
- Child's condition is rapidly deteriorating.

***“A child may have only one or a combination of the above but each of these symptoms is evidence of a real asthma crisis developing!”***

## What to Do:

1. Notify the school nurse (if in the building) that a child may be starting symptoms consistent with an asthma episode and request assistance.
2. If the child begins to wheeze, coughs, is short of breath or even appears more restless or anxious than usual, ask the child to sit quietly in an upright position. Reassure the child in a calm voice and do not leave the child alone.
3. Consult the child's asthma action plan or emergency care plan (if available).
4. If the child carries an inhaler, instruct him/her to use their rescue medication. (Even if you are not sure the symptoms are progressing or prevalent enough, it is safest to give the child a puff of their rescue medication rather than waiting. Many times, the child can tell you immediately if medication is required.)
5. Have the child sit up and breathe evenly, breathing in through nose, and breathing out with pursed lips.
6. If an asthma episode is suspected, give a glass of room temperature water to sip.
7. Elevate arms to shoulder level and provide support for the arms (desk or back of chair).
8. If asthma symptoms do not improve or are progressing rapidly (and/or the nurse is not available to assess the child) call 911.
9. Above all, don't panic! Remaining calm and reassuring the child that he/she will be okay helps alleviate the child's anxiety and may prevent symptoms from becoming worse.



Do not delay administering rescue medications or calling 911 while you attempt to contact the parents/guardian. Time is critical when a severe episode is taking place. The nurse can assess and document the episode and contact the family per district guidelines once the child's symptoms have subsided.

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## Supporting the Student with Asthma

### TIPS FOR TEACHERS

- ✓ Know which children in your class have asthma. A conference with the parent, child, and school nurse may be needed. Discuss the child's asthma, medicines, and management.
- ✓ Know the early warning signs of an asthma episode.
- ✓ Have a copy of each child's asthma action plan or emergency care plan in the classroom. Review it with the child's parents/guardian and school nurse. Know what steps to take in case an asthma episode occurs.
- ✓ If you notice a child chronically coughing in class, and who may have difficulty participating in physical activities, he/she may need to be assessed by a medical provider. Be sure to alert the school nurse about children with breathing difficulties.
- ✓ If a child is using his/her inhaler, be sure to ask about symptoms and confirm that the inhaler relieved those symptoms. Inform the school nurse if a child is using his/her inhaler more than once per day (or frequently) and always keep the child in the informational loop.
- ✓ If you notice that a child is using an inhaler without a spacer, refer that child to the school health office.
- ✓ The best way to support a child with asthma is to treat him/her like all other children while watching for the appearance of symptoms and avoiding triggers.
- ✓ Respect the child's right to privacy and confidentiality.
- ✓ Know the possible side effects of asthma medications. Refer any problem to the school nurse and parents/guardian. Be cautious of making assumptions that a child's medication is causing side effects. Look at the most obvious, common childhood issues first.
- ✓ Reduce allergens and (triggers) irritants in the classroom. This includes prohibiting children from bringing in their cats, dogs, birds or other furry, feathered pets for show and tell. This is a great opportunity to teach classmates about asthma and what triggers episodes. Be sure to explain that "no pets in the classroom" is a district policy (check policies first) and avoid singling out a child who has asthma as the reason for the restriction.
- ✓ Perfumes, body sprays and even hairspray are strong triggers for many children. Be sure to avoid wearing any scents to class and remind older students, parents, visitors and especially volunteers not to wear perfumes, cologne, or scented hair products.
- ✓ Be aware of children who have exercise-induced asthma and have them warm up and pre-treat with inhaler per policies and care plans.
- ✓ Educate classmates about asthma so they will be more understanding of students with asthma and know when to get help from an adult.
- ✓ If a child seems unusually tired, inattentive, or hyperactive, advise the school nurse and the child's parent(s)/guardians. Behavior that is out of character for that child could be related to asthma that is not being properly managed.
- ✓ Encourage parents to work with the school nurse and to provide asthma care plans and to encourage the child to take his/her medication daily (if prescribed).
- ✓ Work closely with the school nurse to support policies and procedures that help a child with asthma participate fully in school each and every day. Be proactive!

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## Teaching equipment, cleaning supplies and teaching aids

- Stuffed animals and toys are traps for dust and allergens. They should be made of synthetic washable material and washed several times a year.
- Chalkboards should be cleaned when children are not present and never allow children to “bang together” the erasers.
- Paints and markers often emit strong fumes. Only use odor free markers in a well-ventilated area. Replace tops when not in use. Consider writing out assignments and other information on a whiteboard when children are not in the room.
- Be cautious with chemical cleaning supplies. Small children cannot read labels and the strong odors from some products can trigger an asthma episode. It is best to avoid using any cleaning products when children who have asthma are present.
- Use natural cleaning agents when appropriate: White or apple cider vinegar can be used to remove mineral deposits and crayon marks. Baking soda is a good general cleaner than can also be used as a deodorizer. Use mild, unscented bar soap for hand washing and encourage children to wash hands frequently to avoid spreading viral/cold germs.

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## Pets/Animals in the classroom

Remove animals from the school, if possible. If removing animals from the school is not possible, then:

- Keep animals in cages or in localized areas as much as possible; do not let them roam.
- Clean cages regularly.
- Locate animals away from ventilation system vents to avoid circulating allergens throughout the room or building.
- Locate sensitive students as far away from animals and habitats as possible.
- Keep animals and cages away from upholstered furniture and carpets. If cages must be kept on a carpeted floor, place a non-permeable surface between the carpet and cage. If using plastic, it should have a thickness of at least 6 mil.

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## Working with Classroom Volunteers

It is important that people who come into the classroom understand that they play an important role when it comes to monitoring a child’s asthma symptoms. Many times volunteers are working directly with children in small reading or art groups. They may perform the role of playground or lunch monitor and at times be the only adult physically interacting with the children. Just like teaching assistants and teachers, they need to know the signs and symptoms of a developing asthma episode.

Any classroom volunteer should be given either this entire section or the Playground Assistants section for review. Both sections explain asthma basics and provide the steps necessary to determine what action(s) should be taken. Reminding them that perfumes, colognes, hairspray and many scented hair products are strong triggers/irritants for many children and should not be worn in the school.

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## Monitoring Outdoor Air Quality/Ozone/Pollution

*Consider making it a daily routine for your class to start each day by checking the air quality index in your general area.*

People with asthma are more sensitive to air quality and poor air quality may be a trigger for an asthma episode. The Air Quality Index (AQI) is tool that can help you understand whether your air quality is good or bad on any particular day.

The AQI ranges from 0 to 500 and in Minnesota is based on measured or estimated levels of five air pollutants: ground-level ozone (smog), fine particulate matter, carbon monoxide, nitrogen dioxide and sulfur dioxide. The Minnesota Pollution Control Agency (MPCA) reports information about air quality on a daily basis on the AQI web site and AQI Information Line (651-297-1630). When the AQI exceeds or is forecast to exceed a value of 100, the MPCA issues air pollution health alerts.

Teachers should be aware that athletes with asthma may experience problems when the AQI exceeds 100. You may sign up to receive e-mail notification when air quality alerts are issued by the MPCA and check the air quality index daily for Minnesota by going to: <http://aqi.pca.state.mn.us/hourly/>

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## Relevant Legislation:



There are legal requirements and statutes that regulate schools working with not only children with asthma but with children with special needs in general. The following are simplified summaries of current statutes.

### FEDERAL LAWS (IDEA 1997) AND SECTION 504 OF THE REHABILITATION ACT OF 1973



These mandates require that schools promote the health, development and achievement of students with asthma, when the disease interferes with their learning. Schools are required to remove “disability barriers” that impede health, participation and achievement. The law requires schools and parents to work together as partners to develop and implement health plans to protect the welfare of the child.

### MINNESOTA INHALER LAW OVERVIEW

Minnesota Statutes, Section 121A.22



The Minnesota legislature enacted language during the 2001 session that allows public elementary and secondary school students to possess and use inhalers prescribed for asthma or reactive airway disease. The following provides an overview of the requirements that must be met before a student is given permission to carry asthma medication and self-medicate in school:

1. The parent has not requested that school personnel administer the student’s asthma medication; *and*
2. The school district receives annual written authorization from the student’s parent for the student to self-administer; *and*
3. The inhaler is properly labeled for that student; *and*
4. The school nurse or other appropriate party assesses the child’s knowledge and skills to safely possess and use his/her inhaler in a school setting and enters a plan to implement safe possession and use of the inhaler into the student’s school health record; *or* for schools without a school nurse or nursing services, the student’s parent or guardian submits written verification from the student’s physician documenting that the physician has assessed the student’s knowledge and skills to safely possess and use his/her inhaler in a school setting.

*Summary, August 2001 ALAMN*

## FAMILY EDUCATION RIGHTS AND PRIVACY ACT (FERPA)



Generally prohibits schools from disclosing personally identifiable information in a student's education record, unless the school obtains the consent of the student's parent or the eligible student (a student who is 18 years old or older or who attends an institution of postsecondary education). FERPA does allow schools to disclose this information, without obtaining consent, to school officials, including teachers, who have legitimate educational interests in the information, including the educational interests of the child. Schools that do this must include in their annual notification to parents and eligible students the criteria for determining who constitutes a school official and what constitutes a legitimate educational interest. Additionally, under FERPA, schools may not prevent the parents of students, or eligible students themselves, from inspecting and reviewing the student's education records.

## SCHOOL BUS IDLING LAW

Minnesota Statutes, Section 123B.885



*Diesel School bus idling:*

"All operators of diesel school buses must minimize, to the extent practical, the idling of school bus engines and exposure of children to diesel exhaust fumes."

*(This pertains to bus drivers lining up buses waiting for the children to exit the school and load the buses. Unless, due to inclement weather (i.e. too cold or too hot), the buses engine should be shut off until all children are loaded onto the bus).*

*Parking:*

"On and after July 1, 2003, diesel school buses must be parked and loaded at sufficient distance from school air-intake systems to avoid diesel fumes from being drawn into the systems, unless, in the judgment of the school board, alternative locations block traffic, impair student safety, or are not cost effective."

*(IAQ can suffer greatly when diesel fuel fumes are pulled into the building and circulated via the ventilation system. These fumes/odors are potent asthma triggers for some children).*

## PESTICIDE STATUTES

Minnesota Statutes, Section 121A.30



The Parents Right to Know Act of 2000. This law requires public and non-public K-12 schools that plan to apply pesticides specified in the law, to provide notices to parents and employees. This law also requires the Minnesota Department of Health (MDH) to develop and make available model notices for schools to use, if they choose to do so.



# Resources

The following resources are located in the Resource Section and on the asthma manual CD-rom. These resources are suggestions forms and programs and can be modified (CD) according to your district policies and procedures. Other resources are listed with Internet link addresses at the back of this manual.

## Power Breathing Program

From Asthma and Allergy Foundation of America, provides a basic understanding of asthma and empowers and motivates teens to take control of their asthma on a personal level. Ordering information available on website. [www.aafa.org](http://www.aafa.org) (teens)

## Asthma Challenge

Also from Asthma and Allergy Foundation of America, is an interactive board game designed to teach the basics of asthma in a group setting. [www.aafa.org](http://www.aafa.org) (teens)

## Open Airways for Schools

From American Lung Association, teaches students steps to take in order to prevent an asthma episode and to better manage their asthma with the assistance of parents, teachers, school nurses, and physicians. The interactive approach utilizes group decision, stories, games, and role-play to promote children's active involvement in the learning process. <http://www.alamn.org/prof/Educators.asp>

## FORMS AND INFORMATION

Student breathing questionnaire  
Asthma/ Breathing Problem Visit Notification  
Emergency care plan  
Asthma action plan  
Asthma first aid poster

### Citations

- <sup>1</sup> National Center for Health Statistics, National Health Interview Survey, 1999.
- <sup>2</sup> "Guidelines for the Diagnosis and Management of Asthma," National Institutes of Health National Heart Lung Blood Institute.
- <sup>3</sup> "Asthma in Children Fact Sheet," American Lung Association, June 17, 2003. [www.lungusa.org/asthma/ascpedfac99.html](http://www.lungusa.org/asthma/ascpedfac99.html)
- <sup>4</sup> "Surveillance for Asthma – United States, 1980–1999," MMWR Surveillance Summaries, Centers for Disease Control and Prevention, March 29, 2002.
- <sup>5</sup> "Update on Food Allergies and Asthma" by Hugh A Sampson, M.D. Food Allergy News, Volume 6, No. 1, October–November 1996.

