

**McLean County Unit District No. 5
Parent Agreement for Child to Carry Asthma Inhaler Medication**

By state law, students in the state of Illinois may carry and self-administer their asthma inhalers while in school, provided that this form and the McLean County Unit District No. 5 Request for Supervised Self-Administration of Medication form is on file at the school where the student attends.

State law requires that the school district inform the parents or guardians of the student, in writing, that McLean County Unit District No. 5 and its employees and agents are to incur no liability whatsoever as a result of any injury that may arise from the self-administration of medication by the student.

The permission for self-administration of medication is effective for the entire school year for which it is granted and shall be reviewed each subsequent school year. A student with asthma may possess and use his or her medication while in school, at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. McLean County Unit District No. 5 recommends, but does not insist, that you provide an additional dose of the medication to be kept in the nurse's office in the event that your child forgets or loses his or her medication.

I/We _____, parent/guardian of

_____, acknowledge that McLean County Unit District No. 5 and its employees and agents are to incur no liability whatsoever as a result of any injury that may arise from the self-administration of medication by the above-named student. I/We hereby indemnify and hold harmless McLean County Unit District No. 5 and its employees and agents against any claims that may arise out of the self-administration of medication by my son or daughter.

I understand the above information, and give permission for my child to carry the medication described below to be used in the treatment of his or her asthma. I will notify the proper school officials of McLean County Unit District No. 5 of any changes in medication as well as any changes in my child's condition. I understand that a McLean County Unit District No. 5 Request for Supervised Self-Administration of Medication form must also be on file at the school and that I need to label my child's inhaler with his or her name.

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency of Use</u>
_____	_____	_____
_____	_____	_____
Parent/Guardian Signature		Date
_____		_____
Physician Signature/Stamp & Phone Number		Date
_____		_____

Asthma Action Plan



General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/Health Care Provider _____ Phone numbers _____
 Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Pre-medication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well **Peak Flow Meter Personal Best =** _____

Symptoms	Control Medications												
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work and play <input type="checkbox"/> Sleeps all night	<table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When To Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When To Take It											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter More than 80% of personal best or _____													

Yellow Zone: Getting Worse **Contact Physician if using quick relief more than 2 times per week.**

Symptoms	Continue control medicines and add:												
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Cough, wheeze or chest tight <input type="checkbox"/> Problems working or playing <input type="checkbox"/> Wake at night	<table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When To Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When To Take It											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter Between 50 to 80% of personal best or _____ to _____	<table border="1"> <tr> <td> IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care </td> <td> IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine </td> </tr> </table>	IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care	IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine										
IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care	IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN <input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine												

Red Zone: Medical Alert **Ambulance/Emergency Phone Number:** _____

Symptoms	Continue control medicines and add:												
<input type="checkbox"/> Lots of problems breathing <input type="checkbox"/> Cannot work or play <input type="checkbox"/> Getting worse instead of better <input type="checkbox"/> Medicine is not helping	<table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When To Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When To Take It											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter Between 0 to 50% of personal best or _____ to _____	<table border="1"> <tr> <td> Go to the hospital or call for an ambulance if <input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> If you have not been able to reach your physician/health care provider for help <input type="radio"/> _____ </td> <td> Call an ambulance immediately if the following danger signs are present <input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue </td> </tr> </table>	Go to the hospital or call for an ambulance if <input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> If you have not been able to reach your physician/health care provider for help <input type="radio"/> _____	Call an ambulance immediately if the following danger signs are present <input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue										
Go to the hospital or call for an ambulance if <input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> If you have not been able to reach your physician/health care provider for help <input type="radio"/> _____	Call an ambulance immediately if the following danger signs are present <input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue												