Notice to parents/guardians re: Asthma Action Plan

While Lakeside School is a private institution, we voluntarily adopt the standard of safety outlined in the law applicable to public schools (RCW 28A.210.320) concerning children with life-threatening conditions, reflecting our commitment to maintaining a similar level of safety and care for our students. 'Life-threatening conditions' refer to those posing a danger to a child's life during the school day without a valid medication or treatment order ("Action Plan"). **Please ensure your student possesses the necessary medications as outlined in the Asthma Action Plan either on their person or securely stored with the school nurse in the Health Room on or before the first day of summer programs/camp.** If a student with such a condition lacks this documentation and medication at summer programs/camp, Lakeside's summer administration is required to exclude them until the necessary documentation and medication is provided. Providing the appropriate Action Plan grants Lakeside's School Nurse authority to administer required care, as mandated by RCW 18.79.260(2),

The "**Asthma Action Plan" substitutes the "Medication at Lakeside School" form if a student solely needs asthma medication at summer programs/camp**. For students needing non-asthma medications, like over the counter or prescription drugs, alongside asthma management, both the "Medication at Lakeside School" form and the "Asthma Action Plan" should be completed. The "Asthma Action Plan" addresses asthma-specific medication needs, while the "Medication at Lakeside School" form encompasses a broader range of medication requirements. Parents and guardians are advised to complete the appropriate form based on the student's specific medication needs.

Forms can be found on Summer at Lakeside Health & Safety page and submitted on CampBrain. If your child has seen their doctor within the last year, *you likely do not need to make an additional appointment to get this form filled out*. Try calling your doctor's office or using MyChart to ask for the completion of the below form.

We appreciate your cooperation in implementing this change to prioritize the safety and well-being of your student.

Lakeside School 14050 1st Ave NE Seattle, WA 98125	Lakeside Middle School 13510 1st Ave NE Seattle, WA 98125

Asthma Action Plan

Please ensure all necessary medications are listed for the school day and for school-sponsored overnight trips. This includes, at minimum, the rescue inhaler. Consider any long-term inhalers or other medications, as applicable to your child's Asthma Action Plan.

Parent/Guardian complete the section below:

Student Name ____

Date of Birth ____________________________**Grade**_________

Valid for: ☐ 2024 summer programs ☐ 2024-2025 school year ☐ 2025 summer programs

Where is emergency medication stored on a standard school day?

(if authorized for self-carry): (ex. in backpack, in fanny pack)

____

Please Check One Box:

☐ I request that authorized persons at my school assist my child in taking medicine described below. I also give my permission for the exchange of information between the school nurse and the Health Care Provider. As a result of this authorization, I agree to indemnify and hold harmless Lakeside School, its agents, employees, and board members against all claims, judgments, or liability who administer and/or monitor the medication.

☐ I request that my child be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and Health Care Provider. I shall hold harmless and indemnify Lakeside School, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child.

☐ I am 18 years or older and am signing this form on my own behalf (RCW 26.28.015 or RCW 70.02.130) to request that I be allowed to self-administer medication. I also give my permission for the exchange of information between the school nurse and my Health Care Provider. I shall hold harmless and Lakeside School, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication.

By signing below, I acknowledge that Lakeside School's policy mandates that if my child receives the below medical treatment for severe breathing difficulties but doesn't exhibit improvement, the school will initiate a 911 call, then will call the parent/guardian. This action will be taken if my child persists in the 'red zone' with trouble walking/talking due to shortness of breath, lips or fingernails are blue, chest and neck pulled in with breathing, stooped body posture, struggling or gasping.

Parent/Guardian Signature:

Date:

Health Care Provider complete the section below:

Student Name____ **DOB** __________________

Valid for ☐ 2024 summer programs ☐ 2024-2025 school year ☐ 2025 summer programs

Action is necessary when student has symptoms such as cough, wheeze, shortness of breath, 15-20 minutes before exercise or

____.

- Give medications as listed below. Student should respond to treatment in 15-20 minutes.
- **Contact 911 immediately for the following symptoms:** Trouble walking/talking due to shortness of breath, lips or fingernails are blue, chest and neck pulled in with breathing, stooped body posture, struggling or gasping or _______________________________________.

Triggers:

☐ Exercise
☐ Strong odors or fumes
☐ Respiratory infections
☐ Chalk dust / dust
☐ Change in temperature
☐ Carpets in the room
☐ Animals
☐ Pollens
☐ Food
☐ Molds
☐ Other:_____________________

MEDICATION	DOSAGE (in mcg) and PUFFS	TIME GIVEN/ FREQUENCY	ROUTE
Rescue inhaler: ☐ Albuterol (ProAir, Proventil, Ventolin) ☐ Levalbuterol (Xopenex)	_____mcg _____puffs	Can administer first dose if symptomatic. Second dose after ______min. Then, can be repeated every ____________ hours.	inhaled
Long-acting/daily inhaler:	_____mcg _____puffs		inhaled

☐ **YES – self carry & self-administer**
I have instructed this student in the proper way to use his/her/their medications. It is my professional opinion that this student should be allowed to carry and use that medication by him/her/their self, unless medically unable to do so.

☐ **NO – self carry & self-administer**
It is my professional opinion that this student should not carry his/her/their medication by him/her/their self. It should be stored in a safe place for quick access and not on their person.

Signature of Licensed Health Provider with Prescriptive Authority:
Date:

Health Care Provider: ____________________________________

Phone ______________________ Fax ____________________

Green zone: Doing well
- Breathing is good - No cough or wheeze - Can work and play - Sleeps well at night
Yellow zone: Getting worse
- Some problems breathing - Cough, wheeze or tight chest - Problems working or playing - Wake at night
Red zone: Medical alert
- Lots of problems breathing   o Struggling or gasping - Trouble walking/talking due to shortness of breath - Lips or fingernails are blue - Chest and neck pulled in with breathing - Stooped body posture

Adapted from American Lung Association