

EXHIBIT 20

DATE 1-28-05

HB 396



Self-Administration of Inhaler Medication Student Agreement

Name: _____ Grade: _____

Inhaled Medication: _____ Date: _____

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Make a note of when I use medication at school.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or school health paraprofessional if the following occurs:
 - My symptoms continue or get worse after taking the medication.
 - My symptoms reoccur within 2-3 hours after taking the medication.
 - I think I might be experiencing side effects from my medication.
 - Other _____
- I understand that permission for self-administration of medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student

Date

- Verbalizes Dose _____
- Verbalizes Asthma Episode Symptoms
- Demonstrates Proper Technique
 - removes cap and shake if applicable
 - attach spacer if applicable
 - breathes out slowly
 - press down inhaler to release medication
 - breathe in slowly
 - hold breath for 10 seconds
 - repeat as directed.
- Verbalizes Safe Use of Inhaler

The student has demonstrated knowledge about and proper use of his/her inhaler.

Signature of Nurse

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

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

| 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

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

| Medicine | How Much to Take | When To Take It |
|----------|------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days
- Change your long-term control medicines by _____
- 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

- Take quick-relief treatment again
- Change your long-term control medicines by _____
- Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

| Medicine | How Much to Take | When To Take It |
|----------|------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if

- Still in the red zone after 15 minutes
- If you have not been able to reach your physician/health care provider for help
- _____

Call an ambulance immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue

Authorization for Administration of Inhaled Asthma Medication

(Use a separate authorization form for each medication)

School: _____

Student's Name: (First/MI/Last) _____

Sex: (please circle) Female Male

Birthdate: ___/___/___

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's Name: _____

Telephone Number: _____ Fax Number: _____

Emergency Contact Number: _____

Diagnosis: _____

Name of Medicine: _____

Form: _____ Dose: _____

Is the child knowledgeable about his/her asthma medication? Yes No

Has the child demonstrated the proper technique in administering medication? Yes No

Medicine is administered daily. Time: _____ Yes No

Medicine is administered when needed. Indications: _____

If needed, how soon can administration of medicine be repeated? _____

The medication cannot be repeated more than _____

Side effects: _____

Comments: _____

() I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

() It is my professional opinion that _____ should not be allowed to carry and use this inhaled medication by him/herself.

Physician Signature/Date: _____

FOR COMPLETION BY PATIENT

Mother's Name: _____

Father's Name: _____

Mother's Work Telephone: _____ Father's Work Telephone: _____

Home Telephone: _____ Emergency Number: _____

Is the child authorized to carry and self-administer inhaled asthma medication? Yes No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature & Date: _____

MANAGEMENT OF AN ACUTE ASTHMA EPISODE IN THE SCHOOL

Adapted from the Asthma and Allergy Foundation of America (AAFA), Washington State Chapter, with permission

Asthma is the leading cause of absenteeism in school-aged children. A school-based asthma management program should allow children with asthma or allergies to participate in all school learning and recreational activities with few restrictions. An effective program will ultimately help to minimize school absences.

| WHAT TO LOOK FOR | WHAT TO LISTEN FOR |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Anxious look <input type="checkbox"/> Stooped body posture <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Dyspnea <input type="checkbox"/> Rapid respirations (greater than 25-30 at rest) <input type="checkbox"/> Retractions <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Depressed sternal notch <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Fatigue <input type="checkbox"/> Decreased peak flow value | <ul style="list-style-type: none"> <input type="checkbox"/> Complaints of chest tightness <input type="checkbox"/> Coughing <input type="checkbox"/> Irregular breathing <input type="checkbox"/> Abnormal breathe sound: <ul style="list-style-type: none"> • Decreased or absent breath sounds • Wheezing • Rales • Rhonchi <input type="checkbox"/> Prolonged expiration <input type="checkbox"/> Rapid heart rate |
| WHAT TO DO IN AN ASTHMA CRISIS AT SCHOOL | SEEK IMMEDIATE EMERGENCY CARE IF STUDENT: |
| <ul style="list-style-type: none"> <input type="checkbox"/> If possible, review the student's Asthma Action Plan for Personal Best, current medications and emergency medications. <input type="checkbox"/> Have student sit upright and check breathing with peak flow meter—if possible. <input type="checkbox"/> Administer prescribed medication by inhaler (medication should be inhaled slowly and fully). OR <input type="checkbox"/> Administer medication by nebulizer if prescribed. <input type="checkbox"/> Reassure student and attempt to keep him/her calm and breathing slowly and deeply. <input type="checkbox"/> Student should respond to treatment within 15-20 minutes. Recheck with peak flow meter. <input type="checkbox"/> If NO change or breathing becomes significantly worse, contact parent immediately and call for emergency help. | <ul style="list-style-type: none"> <input type="checkbox"/> Coughs constantly <input type="checkbox"/> Is unable to speak in complete sentences without taking a breath <input type="checkbox"/> Has lips, nails, mucous membranes that are gray or blue <input type="checkbox"/> Demonstrates severe retractions and /or nasal flaring <input type="checkbox"/> Is vomiting persistently <input type="checkbox"/> Has 50% reduced peak flow reading <input type="checkbox"/> Has pulse greater than 120/minute <input type="checkbox"/> Has respirations greater than 30/minute <input type="checkbox"/> Is severely restless <input type="checkbox"/> Shows no improvement after 15 minutes |