

For 2006-07 school year
[expires at the end of August]

**TREATMENT ORDER FORM: SEVERE ASTHMA
LICENSED HEALTH PROVIDER* [LHP] ORDERS**

NOTE: These orders *must be* renewed annually, prior to the beginning of each school year.

Meridian Park School Shoreline School District 17077 Meridian Avenue North Shoreline, WA 98133	ATTENTION: Donna Allred, RN FAX 206.361-4259 Phone 206.368-4124
---	--

Student name _____ Gender _____ Birth date _____ Age _____

Teacher/IEP/504 Manager [as approp.] _____ Grade _____

Emergency number contacts for parents: Home phone _____

Mom: Cell _____ Work _____ Pager _____

Dad: Cell _____ Work _____ Pager _____

E-mail Mom _____ Dad _____

Name of LHP [print or type] _____ LHP phone _____

LHP Fax _____

**This student has asthma, which is triggered by _____
and may result in a respiratory emergency.**

SIGNS OF SEVERE ASTHMA INCLUDE:

Respiratory: Increased respiratory rate, wheezing, shortness of breath, short utterances, chest tightness, coughing, labored breathing

Cardiovascular: Increased heart rate, dizziness

Gastrointestinal: Nausea, vomiting

Skin: Cool or pale extremities

Mouth: Tingling of lips

**THIS PORTION TO BE COMPLETED BY LHP PRESCRIBING WITHIN THE SCOPE OF HIS/HER
PRESCRIPTIVE AUTHORITY**

If student presents in distress, please prioritize the following steps:

Step # _____ Give medication as ordered: _____

Step # _____ If the above interventions are not improving the student's symptoms, do the following:

Step # _____ Call 911 if: _____

Step # _____ Other: _____

Date of signature

Licensed Health Professional* signature