School/ Center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RN Instructor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PROCEDURE GUIDELINE** | | RN Initials/Date | | RN Initials/Date | RN Initials/Date |
| 1. Confirms written authorization: Parent permission, Physician authorization, up to date Asthma Action Plan | |  | |  |  |
| 1. Verifies pharmacy labels of inhaled medications. Checks expiration dates. | |  | |  |  |
| 1. Confirms presence of respiratory devices indicated on Asthma Action Plan | |  | |  |  |
| 1. Verifies self carry agreement. | |  | |  |  |
| 1. Describes appropriate interventions if medications are not available | |  | |  |  |
| 1. Specific Care Training:  * Identifies individual trigger info * Describes correct use of medication in ‘Green Zone’ instructions * Identifies signs/symptoms indicating ‘Yellow Zone’ medication instructions * Identifies signs/symptoms indicating ‘Red Zone’ medication instructions * Identifies signs/symptoms indicating need for EMS activation * Identifies when to communicate with parent/guardian | |  | |  |  |
| 1. Describes documentation procedure | |  | |  |  |
| 1. Identifies process to locate RN | |  | |  |  |
| 1. Returns demonstration of metered dose inhaler without spacer | |  | |  |  |
| 1. Returns demonstration of metered dose inhaler with spacer | |  | |  |  |
| 1. Returns demonstration of nebulizer | |  | |  |  |
| **I understand the need to confirm current asthma action plan information for each student/child. I have had the opportunity to ask questions and received satisfactory answers.** | | | | | |
| **Delegatee Name (Print)** | **Delegatee Signature** | | **Date** | | |
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Delegating RN Signature: Initials