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
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| 1. Describes documentation procedure
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| 1. Identifies process to locate RN
 |  |  |  |
| 1. Returns demonstration of metered dose inhaler without spacer
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| 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