Guidelines for House Bill 1688

A student with asthma is entitled to possess and self-administer prescription asthma medicine while on school property or at a school related event or activity if:

(a) the prescription asthma medicine has been prescribed for the student as indicated by the prescription label on the medicine;

(b) the self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider;

(c) a parent of the student provides the school a written authorization, signed by the parent, for the student to self-administer prescription asthma medicine; and

(d) a parent of the student provides to the school a written statement from the student's physician or other licensed health care provider, signed by the physician or provider that states:

1. that the student has asthma and is capable of self-administering the prescription asthma medication;
2. the name and purpose of the medicine;
3. the prescribed dosage for the medicine;
4. the time at which or circumstances under which the medicine may be administered; and
5. the period for which the medicine is prescribed.

The physician's statement must be kept on file in the office of the school nurse of the campus the student attends or, if there is not a school nurse, in the office of the principal of the campus the student attends. A person standing in parental relation to a student or the student himself, if over the age of 18, may give permission to use an asthma inhaler under these guidelines.

ASTHMA ACTION PLAN

STUDENT INFORMATION (Attach photo to form)

DATE: _____

NAME: _____ DATE OF BIRTH: _____

CLASS & TEACHER: _____

CONTACT INFORMATION

MOTHER: _____

HOME TEL. #: _____

WORK TEL. #: _____

CELL #: _____

FATHER: _____

HOME TEL. #: _____

WORK TEL. #: _____

CELL #: _____

PHYSICIAN: _____

WORK TEL. #: _____

CELL #: _____

MEDICATIONS

The student may take the following medications during school hours:

☐ Check here if student may carry and self-administer these medications.

NAME OF MEDICATION: _____

DOSAGE: _____

WHEN STUDENT SHOULD TAKE THE MEDICATION: _____

NAME OF MEDICATION: _____

DOSAGE: _____

WHEN STUDENT SHOULD TAKE THE MEDICATION: _____

FIRST AID

The following are specific instructions to be followed should the student have an asthma attack: _____

_____

PREVENTION

The following allergens or irritants are particularly bothersome to the student: _____

_____

SYMPTOMS

The following are symptoms that may indicate the onset of an asthma attack: _____

_____

PARENTAL PERMISSION & RESPONSIBILITIES

I, Parent/Legal Guardian of the above-named student, understand and agree to the conditions of the school policy and the action plan. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate.

If student may administer medication:

☐ I give authorization for self-administration and possession of asthma medication by my child while in school, at school-sponsored activities, while under supervision of school personnel, and while in before-school and after-school care on school-operated property. My child demonstrates a full understanding of the proper use of his/her asthma medication.

I take sole responsibility for:

- Monitoring the asthma medication, medication use, and refilling of prescriptions for asthma medication;
- Ensuring the student always carries his/her asthma medication on his/her person;
- Deciding if backup medication will be kept at the school, and providing the school with the backup medication;
- Informing school staff in writing of any changes in the student's treatment or asthma management or changed medical information; and
- Informing school staff in writing of any medication side effects that the school should notify me about if they occur.

I release the School District and its employees and agents of any legal responsibility related to my child's possession and self-administration of his or her asthma medication.

PARENT SIGNATURE: _____

DATE: _____

STUDENT AGREEMENT

I, _____, understand and agree to the terms of the asthma action plan.

If student is self-administering medication:

☐ I have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances.

STUDENT SIGNATURE: _____

DATE: _____

PHYSICIAN APPROVAL

I agree with the above asthma action plan, including the name, purpose, dosage, and administration directions of the asthma medication.

If student is self-administering medication:

☐ It is my professional opinion that the student should be permitted to carry and self-administer his/her asthma medication. The above-named student has been instructed in, and demonstrates an understanding of, the proper use of his/her asthma medication.

PHYSICIAN SIGNATURE: _____

DATE: _____

NAME: _____

ADDRESS: _____

_____

ASTHMA ACTION PLAN FOR SCHOOL

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise**

allergy (please specify)_____ **other**_____

Current medications for asthma control:_____

_____

Asthma medication to be given at school:_____

_____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: A school district may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs at school, follow these steps:

1._____

2._____

3._____

4._____

Other special instructions: _____

Date:_____**Health Care Provider Signature:**_____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- if my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the health office, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name _____**Phone number**_____

Additional Comments:_____

_____

Parent/Guardian Signature_____**Date**_____

TO BE COMPLETED BY SCHOOL

Date received at school_____

Nurse Signature_____ **Principal Signature**_____