Perry County School District
SCHOOL ASTHMA PLAN

Name: _____ DOB:_____

School: _____ Grade:_____

Instructions to School by the PHYSICIAN ONLY: Circle Yes or No on the below questions: Parent will need to sign at the bottom of page**.**

1. **If coughing or wheezing, give**

   Albuterol, 2-4 puffs with/without spacer and notify parent/guardian: **YES OR NO**

2. **Pre-medication, give**:

   Albuterol, 2-4 puffs, with/without spacer 15-30 minutes prior to exercise.
   YES OR NO

   ****(If #2 the above is circle YES, please write an order to pharmacy because It must be on the pharmacy label)**

3. **Recommend that student be allowed to carry and self-administer all asthma medications: YES OR NO**

4. **Recommend that school nurse &/or school personnel administer asthma medications YES OR NO**

5. Other instructions:

   _____

   _____

Parent signature: _____ Date:_____

Physician (DR.) signature: _____ Date:_____

"Form A"
Medication Administration Form
ASTHMA Page 2

PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel(s) (who will not need a medical or nursing licenses), or school nurse to assist/observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____day of _____, 20_____.

_____ _____

Signature of Parent/Guardian **Witness**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ DOB/Age_____ Grade _____

School_____ Teacher_____ School year_____

HT_____WT_____ Allergies/Reactions_____

I request my child name and identified above to receive:

_____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

_____Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child's medical condition. I authorize the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses),or school nurse to assist/ observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter. **Name of Medication_____**

Signature of Parent/guardian_____Date_____phone#_____

Emergency Contacts: Name:_____ Phone#_____

PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)

StudentName:_____DOB_____Allergies:_____

Name of Medication_____ Strength [**# milligrams(MG**)]_____

Dosage **[# of pills to take/ liquid to take**]_____ Route:_____

Frequency (**Time to be given at school)_____**

Date to begin medication:_____ Date to stop med._____

Reason for taking the medication:_____

Potential side ffects/adversereactions:_____

Any special instructions or Recommendations: _____

Physician Signature:_____ Physician Name: _____

Name of Clinic:_____ Date:_____ Phone #_____

Parent to fill out the back page (page 3)

Perry County School District
Individualized Health Care Plan
Asthma **PAGE 3**

PARENT WILL NEED TO FILL OUT THIS PAGE:

Student Name:_____ Date of Birth:_____ Grade:_____

Homeroom Teacher:_____ Diagnosis:_____ School Year:_____

Nursing Diagnosis (ND)	Nursing Intervention	Nursing goals/outcomes
1. Ineffective airway clearance related to airway spasm, secretion retention, amount of mucus. 2. Potential for ineffective breathing pattern related to spasm of the airway, respiratory muscle fatigue.	*Encourage the student to increase fluids. *Encourage student to maintain medication regimen prescribed by MD. *Monitor the chest wall retraction, respirations, and lung sounds. (ND2) *Administer asthma medications per MD order & have Asthma Action Plan on file. *If no Action plan or MD order on file, contact parent and/or call 911 if needed.	*The student will maintain a patent airway and not experience adverse symptoms *Student will not experience respiratory difficulty. *Student will maintain health and well being necessary for learning and Action Plan will be on file.

I_____(parent/guardian) authorize to the school Administration to designate a school personnel(s)(who will not need a medical or nursing license), or School Nurse to assist/observe my child taking the prescribed medication which is(name of medication)_____ _____ and to perform and carry out the care as outlined in (student's name)_____ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the school nurse, and the designated school personnel (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child's medical condition addressed on this Individualized Healthcare Plan.

Parent/guardian Signature:_____Date_____Phone#_____

Emergency contact person(s) 1. _____ Phone# _____

2. _____ Phone# _____

Perry County School District
Self-Administration of Inhaler Medication
Student Agreement

- *Student to fill out the top part of this form only if student will be self administrating inhaler*
- *The **Nurse at the Dr. Clinic** should complete the bottom part of this page.*

Name: _____ **Grade:** _____

Name of Inhaler:_____ **Expiration Date:**_____

The Student will agree to the following below:

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Make note of when I use medication at school.
- Not allow anyone else to use my medication under any circumstances.
- Keep 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 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**

THE NURSE AT THE DR. CLINIC SHOULD COMPLETE THE BELOW:

□ Verbalize Dose _____

Verbalizes Asthma Episode Symptoms

□ Demonstrates Proper Technique

- removes cap and shake if applicable
- attaches spacer if applicable
- breathes out slowly
- presses down inhaler to release medication
- breathe in slowly
- holds breath for 10 seconds
- repeats as directed.

□ Verbalizes Safe Use of Inhaler: The student has demonstrated knowledge about and proper use of his/her inhaler.

_____ _____

Signature of Nurse **Date**

Perry County School District
DECLINE Asthma Action Plan LETTER

Dear Parents/Guardians:

According to our school records, your child has a history of asthma. State Law requires that each child with asthma have an Asthma Action Plan (AAP) on file at his/her school. Parents and guardians of a child with asthma are to have the AAP developed and signed by the child's healthcare provider. Please have our child's healthcare provider to complete the attached AAP ad return to the school office as soon as possible. We still need the AAP on file at the school no matter if your child does not take any medication or does not use an inhaler. If you have any questions or concerns, please call me at 601-964-1515.

Thank you,

Robin Allen, R.N.
School Nurse

P.S. If you will not be returning the Asthma Action Plan please give reason and sign below.

I am not providing the school with an Asthma Action Plan for my child because:

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date