Dear Parent/Guardian,

Any prescription medication to be given at school must have a medication form signed by the prescribing doctor and parent or guardian. Attached is the medication form. If your child will be taking medication during the school day next year, please have the form completed by first day of school. Any prescription medicine must be in original Rx bottle with child's name and dose to be given at school.

BRACKEN COUNTY HIGH SCHOOL

350 West Miami Street

Brooksville, KY 41004

Phone (606)735-3153

Fax (606)735-2549

Jamey Johnson, Principal

Dear Parent/Guardian,

There is a new law, HB 353, which allows students with asthma to have their inhaler with them at all times while in school. The key points of this new law are as follows:

1. Public and private students are allowed to carry inhalers with them and self-administer their asthma medication.
2. Students must have written authorization from their parent/guardian and a health care provider to do this.
3. The written authorization must be kept on file at school.
4. A parent/guardian must sign a statement acknowledging the school has no liability from injury sustained by a student from self-administration of medication.
5. Permission is to be effective for the school year and renewed each school year.

Your child will not be permitted to carry their inhaler unless we have a written note from you and your health care provider. The statement below must be signed and dated by a parent/guardian.

Thank you,

Jamey Johnson

Bracken County High School

I will not hold Bracken County School System liable for any injury sustained by my child - ______________________________, from self-administration of their medication.

____

Parent/Guardian Signature Date

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: ______________________________ Date form received: ______________

I/we acknowledge receipt of this Physician's Statement and Parent Authorization. ______________________________

Student Name: ______________________ Student age: __________ Date of Birth: __________

Grade: __________ Homeroom/Classroom: ______________________________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: ______________________________

Reason for medication: ______________________________

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ______________

Instructions (Schedule and dose to be given at school): ______________________________

____

Start: ☐ Date form received ☐ Other, as specified: ______________

Stop: ☐ End of school year ☐ Other date/duration: ______________

For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restriction

☐ Yes, Please describe: ______________________________

____

Special storage requirements: ☐ None ☐ Refrigerate

Other: ______________________________

Physician's Signature ______________________ Physician's Name: ______________

Date ______________ Phone ______________ Address: ______________

For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information

☐ On the back side of this form ☐ As an attachment

Signature: ______________________________ Date ______________

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) ______________________ is to receive the above stated medication at school according to standard school policy. I release the Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: __________ Signature: ______________________ Relationship: ______________

Home phone: ______________ Work phone: ______________ Emergency phone: ______________

BRACKEN COUNTY SCHOOL DISTRICT

ASTHMA INDIVIDUAL HEALTH PLAN

Name:	Date:	Student Picture
Birth Date:	Student # :	
School:	Grade:	
What Triggers ASTHMA Problems:		

GREEN - MAINTENANCE	
- Breathing is good - No coughing or wheezing - Can work & play **Peak Flow Number** **to**	**Medication & Dose:** **When to give:**
YELLOW – CAUTION - Coughing - Wheezing - Tight chest **Peak Flow Number** **to**	**Medication & Dose:** **When to give:**
RED - DANGER - Medicine is not helping - Breathing is hard & fast - Nostrils open, flaring - Can't talk well or walk **Peak Flow Number** **to**	**Medication & Dose:** **When to give:** Don't hesitate to call 911

Health Action Plan:

- Do not send student to health room alone.
- Give medication as listed above. Evaluate – are symptoms improving?
- Medication is located in

Other health concerns:

Additional Medications:	Dose/Time:

Inhaler Use Demonstrated to School Nurse: Yes ☐ No ☐

Student can self administer medication: Yes ☐ No ☐

<table>
<tr><td colspan="3">Dietary concerns/restrictions:</td></tr>
<tr><td colspan="2">Parent Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">M.D. Signature (or med. Authorization form):</td><td>Date:</td></tr>
<tr><td colspan="3">CONTACT INFORMATION</td></tr>
<tr><td>Parent/Guardian:
1
2
Email:</td><td colspan="2">Home phone:
Work: Cell:
Work: Cell:</td></tr>
<tr><td colspan="2">Home Address:</td><td>Teacher:</td></tr>
<tr><td colspan="2">Emergency contact:
Relationship:</td><td>Phone:</td></tr>
<tr><td colspan="2">Primary Care Physician:</td><td>Phone:</td></tr>
<tr><td colspan="2">Specialty MD:</td><td>Phone:</td></tr>
<tr><td colspan="2">School Nurse:
Email:</td><td>Phone:
Fax:</td></tr>
</table>

Copies:

- ☐ Parent
- ☐ Teacher (1st___ 2nd___ 3rd___ 4th___ 5th___ 6th____ 7th___)
- ☐ Library
- ☐ Transportation
- ☐ Food Services
- ☐ Health Room