Dear Parent/Guardian:

Our school records show that your student has a history of asthma. The following forms are required each school year for your student to have Emergency Rescue Medication (example - inhalers) in the school's clinic or to self-carry/administer this medication:

1. Authorization for Medication to be Taken During School Hours – Parent/Guardian and physician must complete, sign and return to the school nurse

2. Asthma Individual Health Care Plan – Must be completed, signed by the parent and returned to the school nurse

Your time and effort in completing these forms is greatly appreciated. This is another step in keeping your child safe while getting the best possible education at school. Please feel free to contact your school nurse if you would like to discuss your student's condition or need help completing these forms.

CMCSS ASTHMA INDIVIDUAL HEALTH CARE PLAN

Effective for school year 20___ - 20___ only and MUST be renewed each school year

This page is to be completed by PARENT/GUARDIAN

Student's Name: ____ **Age:** _______

List Known Allergies: ____

Teacher: ___________________________ **School:** ___________________________**Grade:** ______

Please Note **: It is the Parent's/Guardian's responsibility to keep ALL contact/emergency information up-to-date**

Parent(s)/Guardian(s) Name and **BEST** Emergency Contact Information:

Name: __________________________________	Name: __________________________________
phone #: (______)________________(Hm/Wk/Cell)	phone #: (______)________________(Hm/Wk/Cell)

Signs and Symptoms that may occur during an asthma attack (check all that apply):

____ Tightness in chest
____ Shortness of breath
____ Coughing
____ Increased respiratory rate
____ Fear/Anxiety
____ Wheezing
____ Unable to speak without taking a breath
____ Nasal flaring
____ Agitation
____ Other ____

Known triggers that may bring on an asthma episode: ____

____

List any environmental measures/pre-medications/dietary restrictions needed to PREVENT an asthma episode:

____

Emergency Care Plan (check all that apply) and Emergency medication(s):

___ Talk calmly to student
___ Monitor and record lungs sounds until improved
___ Position student comfortably
___ Monitor and record vital signs until improved
___ Encourage deep, slow breathing
___ Assist in administration of emergency medication
___ Notify School Nurse if ____
___ Notify Parent/Guardian if ____

Medication	Dose	Route	When to Use	How soon can it be repeated?
(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)				
911/EMS will be called if student shows no improvement and parent/guardian cannot be reached				

I, as parent/guardian, **DO ___ DO NOT ___** request that my child, named above, be permitted to carry and self-administer emergency medication, and/or equipment, **as ordered by healthcare provider.**

The secure location (on student's person) where emergency medication will be kept:

backpack ___ sports bag ___ purse ___ binder ___ OTHER: ______________________________

I, as parent/guardian, **DO ___ DO NOT ___** require my child's inhaler usage to be monitored by the school nurse.

I, as parent/guardian acknowledge that the school and its employees shall incur no liability as a result of any injury sustained by my child, or any other person, as a result of possession or self-administration of the emergency medication. I shall also indemnify, and hold harmless, the school and its employees against any claim relating to the possession or self-administration of the emergency medication. I also understand that the school may suspend or revoke my child's possession and self-administration privileges if he/she misuses the emergency medication or makes it available for usage by another person.

Parent / Guardian Signature:	______________________________________ **DATE:** __________
School Nurse Signature:	______________________________________ **DATE:** __________
District RN Signature:	______________________________________ **DATE:** __________

(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to and picked up from school by a parent/guardian or his/her adult designee. Children may not bring medication to school or take medication home unless it is an emergency rescue medication that must remain with the student at all times. Prescription Medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose and frequency imprinted on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients.

The following section is to be completed by the PARENT/GUARDIAN:

School:	**Student's Name:**	**Date of Birth:**

I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I also give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

I, ______________________________________, will assume any and all responsibility and liability for any problems

Parent/Guardian's Printed Name

with my child taking this medication at school. I release CMCSS and its personnel from any legal claims which they have now, or thereafter have, arising out of medication taken while at school.

________________ ______________________________________ (____)______________ (____)______________

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications

Name of Medication:

Diagnosis for which medication is prescribed:

Route: **Dose:**

If medication is to be given daily, at what time? (please consider alternate dosing schedule to minimize medication in school)

If medication is to be given "when needed" describe indications:

How soon can it be repeated?

Length of time treatment recommended?
___Current School Year ___Other:________________

List significant side effects:

Provider to initial yes or no for each of the following:

Is student permitted to carry and self-administer emergency rescue medication? **_____ YES _____ NO**

Has student been instructed in self administration of prescribed rescue medication? **_____ YES _____ NO**

Date **Physician's Signature**

Physician's Name, Address and Phone Number: