FREEPORT AREA SCHOOL DISTRICT

ASTHMA ACTION PLAN

Dear Parent/Guardian,

According to our health records, your child has a diagnosis of asthma. In order to provide for the special needs of your child during the school hours and to comply with state mandated regulations, we must have all the attached forms completed and signed.

Students are permitted to carry inhalers. However, the medication procedure form must be signed by both the physician and you, the parent/guardian. In addition to the survey and medication procedure form, you will see a self-administration ability assessment form is included. This form indicates that you feel your child is capable of administering his/her own inhaler. Please complete and sign this form accordingly.

Please contact the school nurse throughout the year of any changes in your child's condition. Your child's welfare is of utmost importance to us. Thank you for your cooperation.

Sincerely,

Cyndi Jones, RN
Secondary School Nurse

FREEPORT AREA SCHOOL DISTRICT
ASTHMA ACTION PLAN

In order to provide for the special needs of your child while he/she is at school and to be in compliance with state mandated regulations, we must have **ALL** medication/asthma forms in this packet completed and returned to the school nurse immediately. Please notify the school nurse if changes occur during the school year.

Child's name _____ Birth date _____ Grade _____

Telephone number _____ Age asthma was diagnosed _____

1. What triggers asthma symptoms in your child? Include items such as exercise/environment/food allergy, etc.

_____

_____

2. Approximately how often does your child have an acute episode?

_____

3. Does your child understand how to manage it? _____

4. In event your child has an asthma attack during the school day, what procedures would you like the school to follow? (**Be very explicit**).

_____

_____

_____

5. **Special Precautions** for GYM class, and/or Sports Participation, or Recess:

_____

_____

6. If your child is on daily medication <u>at home</u> for asthma, please identify:
   Name of the drug(s) _____

   _____

7. If your child is bringing an inhaler or other asthma medication to school, please identify:
   Name of the drug(s) _____

   _____

If your child needs to have medication at school, please have your physician fill out the Medication Procedure Form in this packet. You and the physician must sign it. All medications, including inhalers not specified to be carried by the student, must be kept in the health office.

_____ _____

(Parent/Guardian Signature) (Today's Date)

FREEPORT AREA SCHOOL DISTRICT
SELF-ADMINISTRATION ABILITY ASSESSMENT
Secondary Students

Student's Name	Grade	Date
Name of medication	Dosage	Frequency

To qualify for the privilege of self-medicating, the student must be able to do <u>everything</u> listed below.
To Parent or Guardian: Check all areas that you are certain your child can do well and sign below.

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate to the parent/guardian the proper technique for self-administering his/her medication.

_____ 4. Demonstrate cooperative attitude in all aspects of self-administration of medication.

_____ 5. Demonstrate knowledge of prescribed time intervals for inhaler use.

_____ 6. Inform the certified school nurse, or the school office in her absence, after each inhaler use

I hereby verify that my child demonstrates to my satisfaction the capability for self-administration and responsible use of the medication/inhaler. In addition, as the parent/guardian of above named student, I relieve the Freeport Area School District and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above mentioned medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Parent/Guardian Signature	Date

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the District's medication and asthma policies. I am aware that any improper use/sharing of the above-named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated. I am aware that I am responsible for maintaining a log of my inhaler use and must have it available for review by the school nurse at her discretion.

Student Signature	Date

Student **is** able to self-administer at this time

Signature (Certified School Nurse)/RN Health Assistant	Date

Student **is not** able to self-administer at this time due to the following reason(s):

Signature (Certified School Nurse)/RN Health Assistant	Date

FREEPORT AREA SCHOOL DISTRICT
MEDICATION ADMINISTRATION CONSENT

It is required by the Freeport Area School District that the attending physician completes the following form for all medications to be given during school hours. Please be aware because of the possible unavailability of licensed personnel, that the medication may be administered by a school employee who is neither a registered nurse nor a licensed physician and who has not received any training in the administration of medication.

Student's Name: _____ **Grade:** _____

Shaded area MUST be completed by physician. If attaching a physician statement, this form must be signed by the physician and ALL information requested in the shaded area must be provided on the physician statement.

_____

Condition for which medication is requested

_____

Medication and Dosage

Time given: _____ **Date (to begin):** _____ **Date (to end):** _____

_____

Possible side effects / Emergency response

_____

Physician's name, address, and phone number (please print)

PHYSICIAN: Please check the block below if it applies in this situation (intended only for inhalers, Epi-pens and other life-saving medications).

☐ Student may carry and self-administer medication in school or on a school sponsored activity.

If the above box is checked, it is strongly recommended that an extra dose be given to the school nurse to be kept in school for emergencies.

_____ _____

Physician's signature **Date**

PARENTAL PERMISSION, HOLD HARMLESS AND INDEMNIFICATION

We hereby agree that the medication be administered to our child as stated herein and agree with the intent to be legally bound hereby, to hold the Freeport Area School District and any of its employees or agents harmless from any liability and to so indemnify same for any liability incurred which may result from administration or supervision of the medication by employees or agents of the Freeport Area School District.

_____ _____

Parent or guardian signature Date

FASD Medication Policy requires a parent or guardian to bring the medication to school in the original container or prescription bottle. Return this form to your student's School Nurse. No medications are permitted to be transported on the school bus. A second labeled prescription bottle can be obtained from your pharmacist.