INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR STUDENT WITH ASTHMA/REACTIVE AIRWAY DISEASE (RAD)

TO BE RENEWED EACH SCHOOL YEAR
(If you need assistance completing this form, contact the Licensed School Nurse.)

Student Name_____ Birth Date _____

School_____ Grade_____ Teacher_____ School Year_____

1. **My child still has Asthma/RAD:**
   YES Complete form, sign & date back, and return to your child's school.
   NO Parent/Guardian signature:_____ Date:_____
   (If "No" is checked, do not fill out the remainder of the form, but sign and return to your child's school.)
2. Where does your child receive his/her Asthma/RAD care?
   Health Care Provider/Clinic _____ Phone Number: _____
3. How many times has your child been treated in the emergency department or hospitalized for Asthma/RAD in the past year? _____
4. What triggers your child's Asthma/RAD attacks?
   exercise ☐ weather changes ☐ emotional stress ☐
   upper respiratory infections ☐ smoke ☐
   allergies (please list): _____
5. What are your child's usual signs and symptoms of an Asthma/RAD attack? (Please check all that apply)
   constant/frequent cough ☐ wheezing ☐
   difficulty breathing/talking ☐ chest tightness ☐
   other: _____
6. Does your child recognize these signs and symptoms? YES ◯ NO ◯
7. What does your child do at home to relieve signs and symptoms of an Asthma/RAD attack? (Please check all that apply)
   breathing exercises ☐ drinks liquid ☐
   rests ☐ medication ☐
8. Please list medication taken daily at home for Asthma/RAD:
   Oral: _____
   Inhaled: _____
9. Emergency Contacts (*list in order of who to call first*)

Name:_____ Relationship:_____ Daytime Phone:_____ Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____ Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____ Cell:_____

SCHOOL ACTION/EMERGENCY PLAN

1. Calm and reassure student.
2. Give inhaler/nebulizer if available as authorized by parent/guardian and prescribed by health care provider.
3. Have student in sitting position, encourage slow breathing: in through nose and out through pursed lips.
4. Offer sips of water.
5. Call parent/guardian if student's breathing has not improved or if medication does not relieve symptoms in 15 minutes.

Call 911 if symptoms are not improving with ANY of the following signs or symptoms observed: (*Notify office and parent when 911 is called.)*

-Breathing is hard and fast
-Ribs show
-Student cannot talk or walk
-Nose opens wide to breathe

over

SCHOOL MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

(The Consent Form for Administration of Medication During the School Day for an inhaler and/or nebulizer must be completed and signed by the health care provider and parent.)

No inhaler/nebulizer at school.

- Call parent if attack occurs.
- Follow school emergency plan.

Student needs help with Asthma/RAD signs and symptoms.

- May use inhaler/nebulizer with supervision.
- **The inhaler is properly labeled for the student.**
- Follow school emergency plan.

1. I understand that this information may be shared with all school staff who work directly with my child.
2. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
3. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her Asthma/RAD plan.
4. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
5. Field trips - I give permission for a teacher/school personnel to assist with the administration of the inhaler on a field trip.
6. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's health plan.**
7. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature _____ **Date** _____

LICENSED SCHOOL NURSE SIGNATURE:_____ Date:_____

OR

STUDENT SELF-MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

**Not recommended for elementary students*

(The Consent Form for Administration of Medication During the School Day for an inhaler and/or nebulizer must be completed and signed by the health care provider and parent.)

Student can **self-manage** asthma signs and symptoms, and no inhaler will be carried at school.

- Student will go to the health office if Asthma/RAD attack occurs and parent/guardian will be called.

Student can **self-manage** Asthma/RAD signs and symptoms, and may independently carry and use the inhaler under the following conditions according to the Minnesota Asthma Inhaler Law.

- The parent/guardian must annually submit written authorization for the student to self-manage.
- **The inhaler is properly labeled for the student.**
- The health office staff will assess the student's knowledge and skills to safely possess the inhaler in a school setting. If non-compliance or a change in status occurs, the Licensed School Nurse will contact parent/guardian to discuss a new agreement.
- *Students who self-manage their asthma will NOT be monitored by school personnel on a daily basis.*

1. I request that my child self-manage his/her Asthma/RAD and be responsible for carrying inhaler and administering as ordered by my child's health care provider.
2. I understand that this information may be shared with all school staff who work directly with my child.
3. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her Asthma/RAD plan.
4. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
5. **I understand that my child will inform all staff, including teachers, coaches, and bus drivers, of his/her asthma health plan, and will be responsible to carry their inhaler on field trips**.
6. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature_____ **Date** _____

LICENSED SCHOOL NURSE SIGNATURE:_____ Date:_____

CONSENT FORM FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the LIcensed School Nurse)

****Before medication can be administered by school personnel this form must be completed and on file with the school health office****

Student Name ______________________________ Birth Date ____________________

School __________________________ Grade ________ Teacher __________________ School Year ___________

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PHYSICIAN / LICENSED PRESCRIBER ORDER

I have prescribed the following medication for this student and request the dosage be given during school hours be administered by school personnel

Medication: ____ Dosage:________________ Route: ________________

Time/instructions to be given at school ____

Possible side effects ____

Diagnosis/medical reason for medication________________________________ICD 10 Code _______________

Inhalers/Epinephrine auto-injectors: Child has received instruction and permission to self-carry and independently self-manage Yes No

If Inhaler: With spacer Without spacer

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE:________________________________DATE:________________

PRINT NAME:____ PHONE #:_____________

CLINIC:____FAX #: _______________

PARENT/GUARDIAN AUTHORIZATION

FOR PRESCRIPTION MEDICATION:

1. I request the above medication be given to my child during regular school hours as ordered by the physician/licensed prescriber.
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. **I will provide this medication in the original, properly labeled pharmacy container.**
4. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.
5. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication for my child.
6. I release school personnel from any liability in relation to the administration of this medication at school.
7. I have read and understand the Medication Guidelines included with this form.
8. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

PARENT/GUARDIAN SIGNATURE:____Date:________________

LICENSED SCHOOL NURSE SIGNATURE:____Date:________________

FOR NON-PRESCRIPTION MEDICATION:

Medication ____________________________ Purpose for giving medication ________________________________

Amount & Frequency ____ __________ __________

(Must follow age and weight appropriate package directions) (age) (weight)

1. I request that the above medication be given to my child during regular school hours (no after school activities).
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. **I will provide this medication in the original, properly labeled manufacturer container.**
4. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication for my child.
5. I release school personnel from any liability in relation to the administration of this medication at school.
6. I have read and understand the Medication Guidelines included with this form.
7. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

PARENT/GUARDIAN SIGNATURE:____Date:________________

LICENSED SCHOOL NURSE SIGNATURE:____Date:________________

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, after school, and bedtime. **If a new medication is started, the first dose must be given at home, unless it is a rescue medication.**

1. Administration of prescription medication by school personnel must only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian and Licensed School Nurse. Non-prescription medication may be administered to students with written authorization of parent/guardian and Licensed School Nurse according to label directions.

    a. Mixed dosages in a single container will not be accepted for administration at school.
    b. If a half tablet is required for a correct dosage, it is the parent/guardian's responsibility to provide pre-cut tablets for administration at school.
    c. Altered forms of medication will not be accepted or administered at school.
    d. Narcotics/medical cannabis will not be administered at school.
    e. Aspirin-containing products will not be administered at school.
    f. Only FDA approved treatments will be provided at school.

2. **All medication (prescription and non-prescription) must be brought to and from school by a parent/guardian in its original container.** The following information must be on the prescribed container label:

    a. Student's full name
    b. Name and dosage of medication
    c. Time and directions for administration at school
    d. Physician/licensed prescriber's name
    e. Date (must be current)

3. New consent forms with appropriate signatures must be received each school year.

4. A new medication consent form is required when the medication dosage or time of administration is changed.

5. When a long term daily medication is stopped, a written physician/licensed prescriber's order is requested.

6. Medication will be kept in a locked cabinet in the health office unless authorized by the Licensed School Nurse, and must not be carried by the student.

7. Students (grades 6-12) with severe allergies who need their epinephrine auto-injector during the school day will be allowed to self-manage, carry, and be responsible for the administration of their epinephrine auto-injector with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the Licensed School Nurse.

8. Students (grades 6-12) with asthma who need to use their inhaler during the school day will be allowed to self-manage, carry, and be responsible for the administration of their inhaler with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the Licensed School Nurse.

9. Secondary students may carry and use **non-prescription** medication with written consent of their parent/guardian, signature of student agreement, and with consent of the Licensed School Nurse. This medication cannot contain ephedrine/pseudoephedrine or aspirin as its sole active ingredient or as on of its active ingredients.

10. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.