

Owatonna Public Schools

Asthma Care Plan

Student Information

Name of Student: _____ Date of Birth: _____
Grade: _____ Homeroom Teacher or Class: _____
Physical Education Days and Times: _____

Describe Condition (for example, symptoms of onset): _____

Emergency Information

Parent or guardian name (s'): _____
Mother: Telephone (H): _____ (W) _____
Father: Telephone (H): _____ (W) _____
Physician's name: _____ Telephone: _____

In case of emergency, contact:

1. _____ Telephone: _____
2. _____ Telephone: _____
3. _____ Telephone: _____

Current Medications (any medications given at school must be accompanied by a medication administration form)

<u>Name</u>	<u>Dose</u>	<u>Time given</u>	<u>Given at School?</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Your Child's Asthma Triggers: _____

Emergency Plan

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

Please discuss with your physician the steps you would like the school to take for your child in the case of an acute asthma episode. If in the judgement of school personnel a medical emergency exists, 911 will be called.

Steps To be taken for an Acute Asthma Episode:

1. _____
2. _____
3. _____

Parent/guardian signature: _____ Date: _____
Reviewed by health office: _____ Date: _____

Owatonna Public Schools
Health Services
(OHS and OMS Only)

Parent/Guardian Authorization for Student Self-Administration of Asthma
Inhaler for Asthma or Reactive Airway Disease
(to be completed annually)

Student Name: _____

Parent(s)/Guardian: _____

School: _____ School Year: _____

Name of Prescription Inhaler: _____ Student's Physician: _____

Order for Use: _____ Lot # _____ Exp. Date: _____

1. I authorize my child to self-administer the above named medication during school hours as prescribed by the physician and am requesting the school health service office not administer the medication.
2. I understand my child will carry this medication at school.
3. I also understand my child is entirely responsible for the use of this medication and school personnel will not monitor actual use of this medication.
4. I release all school personnel and I.S.D. #761 from all liability in the event of any adverse reaction from the use or administration of this medication. I hold all school personnel and I.S.D. #761 harmless from any liability resulting from allowing my child to self-administer medications during school hours.
5. I will notify the school of any change in the medication(s).
6. I give my permission for Owatonna School District staff to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

(Parent/Guardian Signature)

(Date)

Asthma Inhaler Law Overview-effective August 1, 2002

Minnesota Statutes 2001, Section 121A.22 (summary from the Minnesota American Lung Association)

The Minnesota Legislature enacted language during the 2001 session that allows public elementary and secondary school students to possess and use inhalers prescribed for asthma or reactive airway disease. The following is an overview of the requirements that must be met before a student is given permission to carry and self-medicate asthma medication in school:

- The parent has not requested that school personnel administer the student's asthma medication; and
- The school district receives annual written authorization from the student's parent for the student to self administer; and
- The inhaler is properly labeled for that student; and
- The school nurse or other appropriate party assesses the student's knowledge and skills to safely possess and use his/her inhaler in a school setting and enters a plan to implement safe possession and use of the inhaler into the student's school health record.

I have assessed the above student has adequate education and knowledge of the use of the above inhaler and can safely possess his/her asthma inhaler in the school setting.

Signature of Nurse

Title Initials

Date