VICTOR VALLEY UNION HIGH SCHOOL DISTRICT
Health Services
16350 Mojave Drive, Victorville, CA 92395-3655
Phone: (760) 955-3201 ext. 10427 Fax: (760)483-7966
Julie Dieppa, RN, BSN Enfermera del Distrito

VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

FORMA DE INFORMACIÓN DEL ASMA DE UN ESTUDIANTE

Nombre del (de la) estudiante: ______________________________ # ID: _______________

Describa el tipo de síntomas que experimenta el / la estudiante (ej., jadeo, dificultad para respirar, tos, etc....) ____

____

Fecha del último ataque de asma ___________________________

¿Cuál es la frecuencia con que el / la estudiante tiene un ataque? Diaria ___semanal___ mensual___ anual___

¿Qué suele causar o desencadenar un ataque? (ejercicio, estrés, clima, enfermedad, etc.)

____

____

Medicamentos que toma el / la estudiante: Nombre, dosis, frecuencia:

____

____

¿Cuáles son los efectos secundarios del medicamento que experimenta su estudiante?:

____

____

¿Su estudiante usa un medidor de flujo respiratorio máximo? ________

Si es así, ¿cuál es el mejor flujo respiratorio máximo actual del (de la) estudiante? ________

¿Su estudiante usa un espaciador para su inhalador? __________

Información / instrucciones adicionales:

____

____

Firma del padre / tutor: ________________________________ Fecha:__________

Teléf. de la escuela: ______________

Fax de la escuela: ______________

Plan de Acción para el Asma – Basado en Síntomas

Symptom Based – Asthma Action Plan

Nombre del Alumno: ______________ **FDN:** ______________ **Escuela:** ______________

Padre/Tutor: ______________ **Teléf: de Casa:** ______________ **Celular:** ______________

Lo siguiente debe ser completado por el MÉDICO: (Artículos #1, 2, 3, y 4):

1. Medicamento(s) (tomado en la escuela Y EN casa):

Por favor MARQUE la casilla si se requiere su uso en la escuela:

A. Nombre del medicamento de *"RÁPIDO ALIVIO"*	1.	☐ Para Escuela *
	2.	☐ Para Escuela *
B. Nombre del medicamento de "RUTINA" (ejem. Anti-inflamatorio)	1.	☐ Para Escuela *
	2.	☐ Para Escuela *
	3.	☐ Para Escuela *
*C. Nombre de m*edicamento para ANTES DE Educ. Física, *Esfuerzo:*	1.	☐ Para Escuela *
	2.	☐ Para Escuela *

2. Para medicamentos inhalados por el alumno (todos los alumnos deben ir con la auxiliar de salud en la oficina para medicamento oral):
- ☐ Auxiliar al alumno en la Oficina de Salúd con medicamento inhalado *
- ☐ Puede autosuministrarse/cargar medicamento para inhalar. * El alumno muestra conocimiento. (No se recomienda en la escuela primaria).

3. Un Espaciador (spacer device) (ejem.: Aerochamber) se aconseja su uso por todos los alumnos en la escuela.

4. Revise los factores que provocan su asma: ☐tabaco ☐pesticidas ☐animales ☐pájaros ☐cucarachas ☐limpiadores ☐humo de carro ☐perfume ☐veladoras ☐humedad/moho ☐polvo ☐aire frio ☐ejercicio ☐smog ☐polen ☐otros

5. Utilizando los siguientes SÍNTOMAS, determine la ZONA apropiada y siga la acción indicada:

Zona Verde

Síntomas: Respira bien, no le falta la respiración por el día o la noche, no hay tos, no hay opresión de pecho, puede hacer ejercicios y sus actividades normales

Zona Amarilla	**Acción para la escuela:**
Síntomas: Comienza a toser, silbido, falta la respiración, opresión de pecho, se despierta por la noche debido a síntomas del asma, o tiene algunas restricciones de actividad	1. Dar medicamento(s) de "Rápido Alivio" 2. Avise al Padre si los síntomas NO mejoran con el medicamento después de 15 o 20 minutos 3. Si los síntomas NO MEJORAN siga el **Plan de Emergencia de la Escuela** abajo indicado 4. Si los síntomas mejoran, el alumno puede regresar a la clase **Avise al padre si se ha utilizado el inhalador más de 2 veces en esta semana (si no es relacionado con actividad física)*

Zona Roja	**Acción para la escuela:**
Síntomas: Tos, problemas para caminar o hablar, retracción de pecho/músculo del cuello al respirar, encorvado, color azul, silbido o sonidos disminuidos en la respiración, falta de respiración, restricción de actividad de moderada a severa, los síntomas permanecen igual o empeoran después de 30 minutos de estar en la Zona Amarilla	1. Dar medicamento(s) de "Rápido Alivio" 2. Si los síntomas no mejoran dentro de los siguientes 15 o 20 minutos con el medicamento de "Rápido Alivio" del alumno, o si los síntomas empeoran, siga el **Plan de Emergencia de la Escuela** abajo indicado

PLAN DE EMERGENCIA DE LA ESCUELA

1. ***REPITA el/los medicamento(s) de*** "Rápido Alivio" ahora
2. ***Llame al 911***
3. *Póngase en contacto con el padre/tutor y la enfermera de la escuela*
4. ***REPITA*** *el/los medicamento(s) de "Rápido Alivio" en 20 minutos si la ayuda no llega y los síntomas no han mejorado*
5. *Permanezca con el alumno hasta que lleguen los paramédicos*

Nombre del Médico: ______________ ***Firma del Médico:*** ______________ ***Fecha:*** ________

Domicilio: ______________ **Teléfono:** ______________

Ciudad: ______________ **C.P.:** ______________

Doy mi consentimiento para que el personal de la escuela se comunique con el médico para consulta e intercambio de información según se requiera.

Firma del Padre o Tutor: ______________ ***Fecha:*** ______________ ***No. de Teléfono:*** ______________

**** Cualquier formulario de Autorización de Medicamento del Médico debe completarse junto con este Plan de Acción.***

School Phone # ________________
School Fax # ________________

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Student Name: ______________________________ **Date of Birth:** ____________________

PHYSICIAN USE ONLY

1. MEDICATION: ____________________ **Dose:** __________ **Reason/Diagnosis:** ________________

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** ____________ **Stop Date:** ____________

☐ **If DAILY ~ Time(s) to be given:** ______________________________

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** ____________

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (<u>**Not**</u> recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): ______________________________

____

2. MEDICATION: ____________________ **Dose:** __________ **Reason/Diagnosis:** ________________

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** ____________ **Stop Date:** ____________

☐ **If DAILY ~ Time(s) to be given:** ______________________________

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** ____________

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (<u>**Not**</u> recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): ______________________________

____

Physician Signature: ______________________________ ***Date:*** ____________

Physician Name: ______________________________

Address: ______________________________ **Phone:** ____________________

City: ______________________________ **Zip:** ____________________

All medication orders will be automatically <u>discontinued</u> at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Parent Request
For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school. ***Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.***

Student Name: ______________________________ **Date of Birth:** ____________________

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. **I hereby request that the staff of my child's school assist in giving medication** to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: ____________________ ***Date:*** ________ **Phone Number:** ____________

B. **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only**: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: ____________________ ***Date:*** ________ **Phone Number:** ____________

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: ______________________________ ***Date:*** ____________

Parent Signature: ______________________________ ***Date:*** ____________

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
(760) 552-6700 • (760) 242-5363 FAX

Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: ______________________ Date of Birth: ____________

School Site: ______________________ LEA of Residence: ____________

Street Address: ____________ City: ____________ State: ______ Zip Code: ______

Home Phone: ____________ Cell Phone: ____________ E-mail Address: ____________

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information: ______________________

Street Address: ____________ City: ____________ State: ______ Zip Code: ______

Contact Name: ____________ Phone: ____________ E-mail Address: ____________

RECEIVING AGENCY

Individual/Agency RECEIVING Information: Victor Valley Union High School District

Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92395

Contact Name: Julie Dieppa, RN Phone: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvuhsd.org

☐ **I agree that the Individuals/Agencies above may mutually share information.**

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

________ **REVOCATION:** I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

________ **REDISCLOSURE:** I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the receipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

________ **HEALTH INFORMATION:** I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

☐ Medical/Medication ☐ Mental Health/Psychiatric ☐ Drug/Alcohol
☐ Educational Records ☐ STD/HIV Test Results ☐ Other: ____________

DURATION: This authorization shall become effective immediately and shall remain in effect until ____________ **(Date)** or for one year from the date of signature if no date is entered.

I request that the information released pursuant to this Authorization be used for the following purposes:

☐ Educational Assessment ☐ Educational Planning ☐ Other: ____________

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: ______________________ Date: ____________

Student Signature: *(if applicable)* ______________________ Date: ____________