long beach unified school district

Office of School Support Services
STUDENT HEALTH SERVICES

Asthma

Dear Parent/Guardian: Date: _____

You have indicated in the past that your student has a history of asthma. By law, we have to have a doctor's order each school year, in order for your student to have an inhaler or other medication at school.

STEP 1
Please let us know your student's current asthma status:

- ☐ My student currently has asthma and may need to use an inhaler at school. *I will sign the attached medication form and have our doctor sign the form. Complete* **STEP 2**
- ☐ My student has a history of asthma but **WILL NOT NEED AN INHALER** at school this year. Please complete attached care plan for asthma.
- ☐ My student does **NOT** have asthma. Please remove this information from my student's list of current health conditions.

Any Comments:

_____

_____

_____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: _____

STEP 2
If you checked the first box, indicating your child needs an inhaler at school, then:

- Sign the front of the attached medication form **AND**
- Have your doctor complete back of medication form.
- Complete enclosed care plan
- Return the completed forms **WITH** medication.
- Contact 504 Coordinator if you would like to set up a 504-information meeting.

Thank you,
Laura Foster
School Nurse
(562) 493-2636

long beach unified school district

Office of School Support Services
Coordinated School Services
STUDENT HEALTH SERVICES

INDIVIDUALIZED HEALTH AND SUPPORT PLAN

(ASTHMA)

Student's name_____ Birthdate _____ Grade_____

Parent's name_____ Home phone _____ Work phone _____

Emergency contact #1_____ Phone _____ Relationship to student_____

Emergency contact #2_____ Phone _____ Relationship to student_____

Doctor's name_____ Phone_____

Hospital _____ Medical Insurance(Kaiser, Medi-Cal, etc.)_____

Student is allergic to:

☐ Medication(s) given at home are:_____

☐ Uses mechanical nebulizer at home with medication

☐ Uses peak flow meter: Normal range is: _____ Times when used: _____

☐ Medication given at school (time) _____

Other: _____

SIGNS OF EMERGENCY:

☐ coughing ☐ difficulty breathing ☐ fast/irregular breathing ☐ sweating

☐ wheezing ☐ shortness of breath ☐ restless/anxious expression ☐ hunched-over posture

☐ complains of tightness and/or pain in chest ☐ use of neck muscles to breathe (tracheal retractions)

Other _____

ACTIONS FOR TEACHER AND/OR OTHER SCHOOL PERSONNEL:

☐ have the student sit in an upright position

☐ reassure the student in a calm voice to relax and breathe slowly and deeply

☐ send student to office for prescribed medication which is kept in locked cabinet in:

(check one): ☐ main school office ☐ nurse's office ☐ other location_____

(If student is having difficulty breathing – call the office and request the nurse or other office personnel come to the classroom with a wheelchair for the student)

☐ monitor student for at least 15 minutes – if no relief in 15 minutes contact parent

☐ CALL 911 – PARAMEDICS if no improvement or symptoms get worse

☐ excuse from physical activity for the rest of the day (playground play, P.E., etc.)

☐ report name of medication and time it was given to parent – send a note home if unable to reach parent

Other _____

Additional information or comments _____

Effective date of Individualized Health and Support Plan: From _____ to _____

PARENT AGREEMENT: I agree with the Individualized Health and Support Plan.

Parent/guardian signature _____ Date _____

School Nurse signature _____ Date _____

(file original copy in STUDENT HEALTH RECORD – copy to parent, teacher, selected school personnel)

Oficina de Servicios de Apoyo Escolar
Servicios Escolar Coordinados
SERVICIOS DE ENFERMERÍA

PLAN INDIVIDUALIZADO DE SALUD Y APOYO

(ASMA)

Nombre del estudiante_____ Fecha de Nac._____ Grado_____

Nombre del padre/madre_____ Teléfono de casa _____ Teléfono del Trabajo_____

Contacto de emergencia Núm. 1_____ Teléfono _____ Parentesco con el estudiante_____

Contacto de emergencia Núm. 2_____ Teléfono _____ Parentesco con el estudiante_____

Nombre del doctor_____ Teléfono_____

Hospital_____ Seguro Médico (Kaiser, Medi-Cal, etc.) _____

TRATAMIENTO NORMAL (de acuerdo a lo indicado por el médico o los padres de familia):

☐ Los Medicamentos que se le dan en casa son: _____

☐ En casa utiliza nebulizador mecánico con su medicamento

☐ Utiliza medidor de flujo máximo: El flujo normal es: _____ veces cuando lo utiliza: _____

☐ Los Medicamento(s) que se le dan en la escuela (hora) _____

Otro: _____

SEÑAL DE EMERGENCIA:

☐ Toser ☐ dificultad para respirar ☐ respiración acelerada/irregular ☐ sudar

☐ Resollar ☐ falta de aliento ☐ expresión de inquietud/preocupación ☐ corazonada-sobre postura

☐ Quejarse de opresión/dolor de pecho ☐ usar los músculos del cuello para respirar (contracciones traqueales)

Otro: _____

ACCIONES DE LOS MAESTROS Y/O PERSONAL ESCOLAR:

☐ Pídale al estudiante que se siente en una posición vertical

☐ Tranquilice al estudiante con voz calmada para que se relaje y respire lento y profundamente

☐ Mande al estudiante a la oficina por su medicamento recetado y el cual se guarda bajo llave en:

(Marque una): ☐ la oficina principal de la escuela ☐ la oficina de la enfermera ☐ otro lugar_____

(S el estudiante está teniendo dificultad para respirar – llame a la oficina y solicite que la enfermera u otro empleado de la oficina vengan al salón de clases y que traigan una silla de ruedas para el estudiante)

☐ Vigile al estudiante por lo menos 15 minutos – si no hay alivio en 15 minutos contacte a los padres del estudiante

☐ LLAME al 911 – PARAMÉDICOS si no hay mejoría o empeoran los síntomas

☐ Excuse al estudiante de las actividades físicas por el resto del día (juegos del patio de recreo, etc.)

☐ Repórteles a los padres del estudiante el nombre del medicamento y la hora en que se le dio – envié una nota a casa si no puede comunicarse con los padres del estudiante

Otro_____

Información adicional o comentarios_____

Fecha de efectividad del Plan individualizado de salud y apoyo: De_____ a_____

ACUERDO DE LOS PADRES DE FAMILIA: Yo estoy de acuerdo con el Plan Individualizado de Salud y Apoyo.

Firma de los padres/tutor _____ Fecha _____ Firma
la enfermera escolar _____ Fecha _____

(file original copy in STUDENT HEALTH RECORD – copy to parent, teacher, selected school personnel)

long beach unified school district

Office of School Support Services
STUDENT HEALTH SERVICES

MEDICATION AT SCHOOL – PARENT'S REQUEST

(A separate form is needed for each medication)

Dear Parent/Guardian,

Medical treatment is the responsibility of the parent and family physician. Medications are rarely given at school; the only exceptions involve special or serious problems where it is deemed absolutely necessary by the family physician. The parent is urged to work out a schedule, with the help of the family physician, for giving medication at home, outside school hours if possible.

The law allows for school personnel to assist in carrying out a physician's recommendation; therefore, in the absence of the school nurse, the principal, teacher, secretary or clerk may be the person administering the medication. If medication is to be administered at school, you **must** provide the school with **all** of the following:

1. A written statement from the physician clearly specifying the condition for which the medication is to be given, dosage, time, and specific instructions for emergency treatment in case of an allergic reaction must be provided to the district. If a nurse practitioner (NP) or a physician's assistant (PA) writes the medication order, their California furnishing number and the name of their supervising physician **must** be included.

2. The parent/guardian must sign a request for administration of medication at school.

3. Medication needs to be delivered to the school by the parent/guardian or other responsible adult.

4. Medication must be in the original pharmacy labeled container, clearly stating all prescription information (name of medication, dosage, how to be given and the time). It is suggested you request two containers from your pharmacist – one for home and one for school.

5. Original copy of a FAX order **must** be mailed to the school within 5 days.

Please discuss your physician's instructions with your child so that he/she is aware of the time medication is due. In the case of a disabled student who requires medication during the school day to effectively participate in the educational program, district personnel will ensure that it is administered with assistance on a consistent basis. Please arrange with the school to pick up leftover medication by the last day of the school year. Medication(s) left at school at the end of the school year will be discarded.

THIS REQUEST IS VALID FOR THIS SCHOOL YEAR ONLY. ANY TIME THERE IS A CHANGE IN MEDICATION (name, dose, time, etc.), NEW PHYSICIAN'S AND PARENT'S REQUEST FORMS ARE REQUIRED.

Parent/Guardian Agreement:

I, the parent/guardian of _____ , Birthdate _____
request medication be administered to my child in accordance with the physician's written instructions on the reverse side of this form. I understand that if the school nurse is not available, other trained school personnel will administer the medication. I will notify the school immediately if I change physicians, or when the medication is changed in any way (e.g., dose, method of administration, time, etc). I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed on the back of this form.

Parent/guardian signature_____ Date_____

Home Phone_____ Work phone_____Cell phone_____

(PHYSICIAN MUST COMPLETE OTHER SIDE)

MEDICATION AT SCHOOL – PHYSICIAN'S REQUEST
(A separate form is needed for each medication)

Student's Name_____Birthdate _____

DIAGNOSIS for which medication is to be given: (If for an allergy, please specify what type - localized, generalized, mild, severe, etc).

_____

PLEASE PRINT:

Name of medication_____

Dose_____

Specific time (e.g. 10 am, noon, etc)_____
(For PRN medications, please indicate why medication should be given (e.g. for wheeze, headache, etc.)

Reactions that need to be reported to the physician_____

_____

Medication to be continued as above until this date:_____

PHYSICIAN'S AGREEMENT: This medication cannot be scheduled for other than during school hours, and I understand that the medication may be administered by non-medically trained school personnel whenever necessary.

_____ Date:_____
Signature of licensed physician ***(NP must have physician's co-signature or name stamp of physician. NP must have license number.)***

_____ Phone:_____
Please **PRINT** name of licensed physician and surgeon)

_____
Address/facility stamp **(medication will <u>not</u> be accepted without stamp)**

Nurse practitioner (NP) or physician's assistant (PA) <u>must</u> complete:

Printed NP/PA name_____ CA furnishing number_____

Signature of NP/PA_____ Date_____

Name of supervising physician_____

****

(For school use only)

Principal's Signature_____ Date_____

School Nurse's Signature_____ Date_____

(PARENT/GUARDIAN MUST SIGN ON THE OTHER SIDE)