MANKATO MN AREA PUBIC SCHOOLS HEALTH SERVICE

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

TO BE RENEWED EACH SCHOOL YEAR

Student Name _____ Birth Date _____

School_____Grade _____Teacher_____School Year _____

1. **My student still has Asthma/RAD:**

- ◯ **YES** - Complete this form, sign & date, and return to your student's school.
- ◯ **NO** - Skip to the end of this form, sign & date, and return to your student's school.

2. How many times has your student been treated in the emergency department or hospitalized for Asthma/RAD in the past year? _____

3. What triggers your student's Asthma/RAD attacks? (Please check all that apply)

- ☐ exercise
- ☐ weather changes
- ☐ emotional stress
- ☐ upper respiratory infections
- ☐ smoke
- ☐ allergies (please list) _____

4. What are your student'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: _____

5. Does your student recognize these signs and symptoms? ◯ YES ◯ NO

6. What does your student do at home to relieve signs and symptoms of an Asthma/RAD attack? (Please check all that apply)

- ☐ breathing
- ☐ drinks liquid
- ☐ exercises rests
- ☐ medication

7. Please list medication taken daily at home for Asthma/RAD: Oral:_____ Inhaled: _____

8. Will your student have medication at school? ◯ YES ◯ NO

If Yes, where will the mediation be kept ◯ in the Health Office ◯ with the student.

9. Name of Health Care Provider_____ Clinic_____ Phone_____

10 .Emergency Contacts (*list in order of who to call first*)

Name: _____ Relationship:_____ DaytimePhone:_____Cell:_____

Name: _____ Relationship:_____ DaytimePhone:_____Cell:_____

Name: _____ Relationship:_____ DaytimePhone:_____Cell:_____

SCHOOL ACTION/EMERGENCY PLAN

1. Calm and reassure the student.
2. Give inhaler/nebulizer if available as authorized by parent/guardian and prescribed by the health care provider.
3. Have the student in sitting position, encourage slow breathing: in through nose and out through pursed lips.
4. Offer sips of water.
5. Call the parent/guardian if the 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

SCHOOL MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

Please select one

◯ No inhaler/nebulizer at school.

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

◯ Student needs help with Asthma/RAD signs and symptoms.

- May use inhaler/nebulizer with supervision. A ***Medication Consent*** form must be completed and signed by the health care provider and parent/guardian.
- The inhaler is properly labeled for the student.
- Follow the school emergency plan.

◯ Student can **self-manage** Asthma/RAD signs and symptoms, and may independently carry and use the inhaler.
(*Not recommended for elementary students*)

- A ***Medication Consent*** form must be completed and signed by the health care provider and parent/guardian indicating the student can self manage.
- The inhaler is properly labeled for the student.
- Students who self-manage their Asthma/RAD will NOT be monitored by school personnel on a daily basis.
- 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 the parent/guardian to discuss a new agreement.

PARENT/GUARDIAN AUTHORIZATION

1. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding his/her health plan.
2. I authorize the Licensed School Nurse/designee to exchange information with my student's health care provider related to his/her health plan.
3. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
4. I understand if my student 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 student's health plan.

Parent/Guardian Signature _____ **Date** _____

Licensed School Nurse Signature _____ **Date** _____

CONSENT FOR ADMINISTRATION OF EMERGENCY ASTHMA/RAD MEDICATION DURING THE SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

****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_____

PHYSICIAN/LICENSED PRESCRIBER ORDER

Medication: _____ Dose: _____ Route: _____

Inhalers: _____With Spacer _____ Without Spacer

Time/instructions to be given at school: _____

Possible side effects: _____

Diagnosis/Medical reason for medication _____ ICD 10 Code_____

Student has received instruction and permission to self-carry and independently self-manage: ___Yes ___No

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE:_____DATE_____

PRINT PHYSICIAN'SAME_____PHONE#_____

CLINIC:_____FAX #_____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my student during regular school hours by designated personnel as delegated, trained, and supervised by the Licensed School Nurse and ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the Licensed School Nurse/designee to exchange information with my student's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my student.
5. I release school personnel from any liability in relation to the administration of this medication at school.
6. I will contact the Licensed School Nurse/designee if a change in the current medication is indicated.
7. Field Trips - I give permission for the trained school personnel to administer the medication on a field trip.
8. I have read and understand the Medication Guidelines included with this 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 where 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 and non-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, regardless of the student's age.

    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 licensed health care provider and parent/guardian 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 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 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 physician/licensed prescriber, parent/guardian, signature of student agreement, and with the consent of the Licensed School Nurse. This applies to all secondary students, regardless of age. This medication cannot contain ephedrine, pseudoephedrine, aspirin or medical cannabis. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.