ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade_____

❒ School E-mail _____ ❒ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ❒ Office Phone (___) _____

❒ Office E-mail _____ ❒ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

MONITORING	TREATMENT
RED **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ❒ Recess ❒ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

❒ Administer medications as instructed above

❒ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school

❒ Student needs supervision or assistance to use his/her inhaler medication

❒ Student should **NOT** carry his/her inhaler while at school ❒ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**

SCHOOL INFORMATION FORM FOR A STUDENT WITH ASTHMA OR BREATHING PROBLEMS

Dear Parent/Guardian: The school nurse needs more information to help take care of your child at school. Please complete and return this form to school. If you have any questions, Please contact your child's school nurse.

Student Name: _____ Birth Date: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Other Emergency Contact Name: _____ Phone: _____

Health Care Provider for Asthma: _____ Phone: _____

1. How much does your child's asthma bother or interrupt him/her during normal activities (playing, running around, sports)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the Time

2. How many times has your child been to the emergency department or hospitalized for asthma in the past year?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐4 times ☐ 5 or more times

3. What triggers your child's asthma? (Check all that apply)
   ☐ Illness (colds) ☐ Smoke Allergies: ☐ cat ☐dog ☐ dust ☐ mold ☐ pollen
   ☐ Emotions (crying, stress, laughing) ☐ Exercise/physical activity ☐ Food: _____
   ☐ Weather Changes ☐ Strong Odors/Smells ☐ Other: _____

4. Does your child have a life threatening allergy or anaphylaxis? ☐ yes ☐ no
   -If yes, is an Epi-Pen at school? ☐ yes ☐ no **If yes, complete an Allergy Action Plan, available from the school nurse.

5. Does anyone smoke around your child (at home, childcare/sitter, family/friends)? ☐ yes ☐ no

6. Describe the symptoms your child typically experiences before or during an asthma episode: (Check all that apply)
   ☐ Coughing ☐ Rubbing chin/neck ☐ Clearing the throat
   ☐ Trouble breathing ☐ Breathing hard/fast ☐ Feeling tired/weak
   ☐ Wheezing ☐ Runny nose ☐ Other: _____

7. Please write the names of the medicines (inhalers, pills, liquids, nebulizers) your child takes for asthma and allergies (both daily and as needed medications).

8. How well does your child take his/her asthma medication? (Check only one answer)
   ☐ Takes Medication by Self ☐ Needs Supervision Taking Medication ☐ Not Using Medication Now

9. In the past 4 weeks, how often has your child used a rescue or reliever medication (inhaler or breathing machine) to relieve coughing, trouble breathing, or wheezing?
   ☐ None ☐ 1-2 days/week ☐ 3 or more days a week ☐ Everyday

10. In the past 4 weeks, how often has your child had coughing, trouble breathing, or *wheezing in the morning or during the day*?
    ☐ None ☐ 1-2 times ☐ 3 or more times ☐ Every day/Nearly every day

11. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing *at night while sleeping*?
    ☐ None ☐ 1-2 times ☐ 3 or more times ☐ Every day/Nearly every day

Parent Signature: _____ Date: _____

Reviewed by School Nurse: Name _____ Date: _____

DUNELAND
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER PRESCRIPTION & NON-PRESCRIPTION MEDICATION

NAME _____ **SCHOOL** _____ **GRADE** _____

☐ SCHEDULED

MEDICATION _____ **DOSAGE** _____ ☐ AS NEEDED **TIME** _____

REASON FOR GIVING _____ **START DATE** _____ **END DATE** _____

THIS SECTION REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

_____
Physician Signature
(Or copy of current label)

I have prescribed the medication(s) below and authorize the nurse or the principal designee to administer the medication(s) as follows with time adjustments to accommodate lunches, late arrival, early dismissal, etc.

This patient has demonstrated they are capable of following the instructions regarding safe and appropriate use of this emergency medication and should be permitted to carry this medication provided permission has been granted per school guidelines *(Controlled substances not permitted to be carried by student).*

_____
Physician Signature
(Must be signed for student to self-carry)

_____ _____ _____
Healthcare Practitioner Name (Printed) **Phone Number** **Date**

PARENT AGREEMENT/AUTHORIZATION:

- The nurse and/or the principal designee has my permission to administer this medication to my child as prescribed and/or directed
- The parent/guardian is responsible for supplying this medication to the school in an original labeled container (this includes pharmacy labels for prescription medications)
- The parent/guardian is responsible for replacing medications on/before their expiration dates
- Changes to the medication dosage and/or administration frequency require a new Authorization to Administer Medication Form be completed along with physician signature or updated pharmacy label for prescription medications
- Authorization to Administer Medication Form must be renewed each school year
- Student's may not be in possession of or transport medications without a current Authorization to Administer form on file
- Medications not picked up at the end of the school year will be disposed of properly
- Parent/Guardian is responsible for notifying the nurse or principal designee if the medication is not to be given for any reason (late arrival, early dismissal, discontinuation, etc.)

_____ _____ _____
Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

DUNELAND
HEALTH SERVICES

Student Name: _____ Date: _____ Class: _____

Dear Parents/Guardian,

In preparation for the end of the school year, we must coordinate the return of any remaining medication your child has at school. Per Duneland School Corporation policy, medication that is possessed by a school for administration during school hours may be released to the student's parent/guardian or to an individual who is 18 years of age or older and who has been designated, in writing, by the student's parent/guardian to receive the medication. A school may send medication not classified as a controlled substance that is possessed by a school for administration during school hours with a student only if the student's parent/guardian provides written permission for the student to receive the medication. The completion of this form and submission to the school nurse serves as an official written permission.

Medication Returned:	QTY	NAME OF MEDICATION
	_____	_____
	_____	_____
	_____	_____

_____ I will pick up my child's medication by _____ and understand that any medications not picked up on or before Thursday, May 30, 2024 or medications not being forwarded to summer school will be discarded.

_____ Please send my child's medication home no sooner than_____ (Controlled substances cannot be sent home with student)

_____ Please forward my child's medication to _____school for 2024 summer school

_____ I authorize _____ who is at least 18 years of age to pick up my child's medication on or before Thursday, May 30, 2024

_____

Parent/Guardian Name (Printed)

_____ _____

Parent/Guardian Signature Date

Inspire | Engage | Empower

The following page (Consent for Release of Medical Information Form) only needs to be completed and signed by a parent/guardian if you prefer for the nurse to fax all the necessary forms to the physician to be completed. After signing this and all the required forms, please send them to the school to be faxed to the physician.

DUNELAND SCHOOL CORPORATION
601 W Morgan Avenue; Chesterton, In 46304
219-983-3600 fax 219-983-3614

Student/ Patient Name:_____ Date of Birth:_____

☐ Send from: ☐ Send to:	☐ Send from: ☐ Send to:
Duneland School Corporation **(and its affiliates, employees and agents)** **601 W Morgan Avenue Chesterton, In 46304** **219-983-3600 fax 219-983-3614** Attn: (name and title): _____	Agency: _____ (and its affiliates, employees and agents) Address: _____ City/State: _____ Phone number: _____ Fax number: _____ Attn: (name and title) _____

A. Information to be disclosed:

Typical **School** Information)

☐ Transcripts, report cards, attendance reports
☐ School Health Records
☐ RTI Data/General Education Referral
☐ Specialized/Diagnostic Evaluation
☐ Special Education Records/Psychological Evaluation
☐ Discipline and Behavior Records
☐ Other _____
_____

(Specific Mental Health/Health Agency Information to be released)

☐ Entire medical record including all of below:
☐ Medical History/Hospitalization
☐ Summary of Psychiatric Treatment
☐ Medication History
☐ Psychiatric Evaluation Results
☐ Mental Disorder/Diagnosis
☐ Most Recent Contact Date
☐ Drug and Alcohol Information
☐ Treatment Plan
☐ Clinician's Office Notes
☐ Patient Histories
☐ Test Results
☐ Records sent to you by other health care providers

By signing here, _____, I give specific authorization to disclose the following:

☐ HIV test results ☐ Drug and alcohol abuse treatment records ☐ Psychotherapy notes
☐ Documentation of AIDS diagnosis ☐ Psychiatric/Mental health treatment records

B. Purpose of Disclosure:

☐ At the request of the individual or ☐ Other:_____
_____

C. Authorization to Discuss Health Information

☐ By initialing here _____ (Initial) I authorize _____ (Name of individual health care provider) to discuss my health information with the School listed here:

_____
(Name of individual or school entity)

D. Authorization Statements:

- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the Superintendent of Duneland School Corporation, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

_____ _____
Signature of Adult Consenting to Release (Either Employee or Parent) Date

_____ _____
Student Signature (if aged 12 or older) Date