ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2024-2025

ROCHESTER COMMUNITY SCHOOLS
ASTHMA Care

Child's picture
Face only

This form must be completed, signed, and ATTACHED to an Asthma Medical Action Plan (MAP). Your child's health care provider will choose to either use their own MAP template, OR the Allergy MAP template listed on the RCS website.

Student's Name: _____ School: _____
Date of birth: _____ Age: _____
Grade: _____ Teacher**:** _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 school year.

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

For asthma symptoms, my child has/uses the following:

☐YES ☐NO Spacer (with or without a mask)
☐YES ☐NO Medication at home to control asthma

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

☐YES ☐ NO I will supply the school with a back-up inhaler, if my child is to self-carry.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

School Office Use ONLY
Auto-injector type:
Expiration date:

Asthma Action Plan for Home & School

Allergy & Asthma Network

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.

Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

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Authorization for Medication Administration
School Year: 2024-2025

Student name: _____ Date of birth: _____ Grade: _____

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: _____ Reason for medication: _____

Dose (***please do not give a range***): _____ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: _____

_____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: _____

☐ Routine time(s) to be given: ☐ _____ AM ☐ _____ PM ☐ Other: _____

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): _____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

_____

_____

Special instructions or side effects: _____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable
Student may self-carry an Epi-Pen (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received ☐ Other date/duration (please be specific): _____
STOP: ☐ End of school year ☐ Other date/duration (please be specific): _____

☐ For episodic/emergency events only

Prescriber Name: _____ Signature: _____ Date: _____

Clinic/Hospital Name: _____ Address: _____

Phone number: _____ Fax number: _____

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the District of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.
☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: _____ Signature: _____ Date: _____

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Medication Procedures

(as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.