MARYSVILLE
Exempted Village School District

Dear Parent/Guardian,

You are receiving this letter because you have indicated that your child has asthma. Enclosed are the forms to be completed by you and your child's healthcare provider. To ensure quality of care please return the forms indicated in the checklist below to the health clinic at your child's school. The forms will need to be completed each school year.

Asthma Form Checklist

If medication will be administered by designated staff, the following forms should be completed:

- ☐ ***Administration of Medication Request (Form MEVS H-2)***
  (Must be completed by the healthcare provider and signed by the parent/guardian)
- ☐ ***Asthma Action Plan***
  (Must be completed by the healthcare provider and signed by the parent/guardian)
- ☐ ***Physician ordered medication(s) in the original packaging***

If your child will self-carry his/her inhaler, the following forms should be completed:

- ☐ ***Authorization Form Self-Medication- Asthma Inhalers (Form MEVS H-3)***
  (Must be completed by the healthcare provider and signed by the parent/guardian)
- ☐ ***Asthma Action Plan***
  (Must be completed by the healthcare provider and signed by the parent/guardian)
- ☐ ***Physician ordered medication(s) in the original packaging***
  (It is recommended that one inhaler is stored in the clinic)

If your child will be self-carrying an inhaler, please send in an additional inhaler to be stored in the clinic for emergencies or if your child should forget to bring his/her inhaler to school. In addition, if designated staff will be administering medication, please provide any needed devices or supplies (e.g. spacer, nebulizer attachments) that are specified in the physician's order.

If you have any questions, please contact the health clinic at your child's school.

Thank you,

Health Services

Innovate Collaborate Inspire

MARYSVILLE
Exempted Village School District

Board of Education
1000 Edgewood Dr.
Marysville, OH 43040
Office 937-578-6100
Fax 937-578-6113
www.marysville.k12.oh.us

ADMINISTRATION OF MEDICATION REQUEST(Form MEVS H-2)

This form must be completed by both the physician who prescribes the medication and the parent or guardian of the student prior to school personnel being permitted to administer medication.

PHYSICIAN'S REQUEST (all items MUST be completed)

_____
NAME OF STUDENT – Print **DOB**

_____
Complete Address **Phone**

is under my care for **(Condition)** _____

and should receive **(Exact Name of Drug)** _____

in the following dosage **(Exact Amount)**_____and route_____

at the following time(s) **(Exact Hours)** _____

Beginning on (date) _____ and ending on (date) _____

This medication may cause the following adverse reactions which should be reported to the undersigned immediately

_____

This medication requires the following special storage or sterile conditions (note: the school will provide storage for drugs needing refrigeration)

_____

Physician's Name (Print) _____

Physician's Complete Address _____

Office Telephone _____ Alternate Emergency Phone No _____

Physician's Signature_____**Date**_____

PARENT OR GUARDIAN'S REQUEST

_____
NAME OF STUDENT – Print Building/Class Grade

I _____ parent/guardian of _____
Parent/Guardian – Print Student's Name – Print

Hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer the medication prescribed as directed by the physician or parent, for the following prescription drug

_____to my child.
Exact Name of Drug

I also agree to comply with the Ohio law which requires me to deliver the medication to the school in its original container and to comply with the guidelines of school Board policy which requires me to receive the medication at its expiration date or the end of the school year, whichever occurs first and any other procedures which the Board may establish.

I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

Parent/Guardian's Signature _____**Date**_____

This medication request form has been properly completed by both the physician and the parent/guardian, and the school will administer the medication as outlined.

Principal's or Designee's Signature _____**Date**_____

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AUTHORIZATION FORM SELF-MEDICATION - ASTHMA INHALERS (Form MEVS H-3)

This form must be completed by both the physician who prescribes the asthma inhaler and the parent or guardian of the student and delivered to the building principal and clinic staff, if any, assigned to the student's building, prior to the student's self-medication or possession of a metered dose or dry powder inhaler.

PHYSICIAN'S REQUEST (all items MUST be completed)

_____
NAME OF STUDENT – Print DOB

_____
Complete Address Phone

Name of Medication in Inhaler _____ Contains _____doses of medication

Date Self-Administration to Begin (if known) _____ Date Self-Administration to End _____

Instructions/Procedures of school personnel to follow if expected relief from asthma attack is not produced by medication as self-administered: _____

_____

_____

Possible severe adverse reactions:
To Student Self-Administering Medication (to be reported to physician) _____

_____

To children using inhaler for whom it is not prescribed _____

_____

Other Special Instructions _____

_____

Physician's Name (Print) _____

Physician's Complete Address _____

Office Telephone _____ Alternate Emergency Phone No _____

_____
Physician's Signature **Date**

PARENT OR GUARDIAN'S REQUEST

_____
NAME OF STUDENT – Print Building Grade

_____
Complete Address Phone

I_____, parent/guardian of _____
Parent/Guardian – Print Student's Name – Print

Authorize my child to self-administer the medication described on this form as directed by the child's physician. I also agree to comply with Board policy and regulations regarding self-administration of asthma inhaler medication. I also agree to submit to the building principal and clinic staff assigned to my child's school building, if any, a revised authorization if any of the information contained in the Physician's Authorization or on my authorization changes.

I also understand that pursuant to Ohio Revised Code Section 3316.716, the Board of Education and its employees are not liable for my child's self-administration of this medication.

_____ Date: _____
Parent/Guardian's Signature

Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION.

Name _____ **DOB** ____/____/_____

Severity Classification ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐Home ☐School
				☐Home ☐School

Physical Activity ☐Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐with all activity ☐when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐Continue Green Zone medicines

☐Add _____ ☐Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐**Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (____) ____-_____ Signature _____

Parent/Guardian

☐I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

☐I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

School Nurse

☐The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

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