SAYRE
SCHOOL
MAKE·YOUR·MARK

Dear Parents and Guardians,

We want to introduce ourselves and create the beginnings of a partnership in your student's health. We are best able to care for your child if we have the information that we need to respond quickly and efficiently. Please contact us with any information that may be important in caring for them.

Please find attached our required forms for asthma, anaphylaxis, and medication administration. We wanted to review our basic protocols and ask for your help. If medication is potentially needed during the school day, please send it to school in a Ziplock bag labeled with their name. The medication should clearly show their name, medication name, and dosage instructions on the pharmacy label. Please let the nursing staff or division administrator know to expect that medication to be delivered that day. These medications should correlate with the medication administration form that is on file.

In the Preschool and Lower School, inhalers and epi-pens will be stored in a red backpack in the child's classroom. These bags go with your child throughout the day when they leave the classroom.

In Middle and Upper School, these medications can be stored in the division office (preferable) or in the child's bag. If the child is involved in after-school activities that take them to the athletic complex, these medications should be carried in a backpack that goes to each location. Most importantly, please communicate with the nursing staff as to where the medication is kept. Please check in with your child periodically to ensure that the medication is where it is expected to be.

Other medications that are emergency medications will be stored in either the appropriate division office or the nursing office.

Please advise us as to your intentions:

☐ Emergency Medication will be stored in the red backpack (Preschool and Lower School Only)

☐ Emergency Medication will be stored in the appropriate division office

☐ Emergency Medication will be stored in the child's backpack

☐ Other medication _______________________(med name) will be stored in the appropriate division office

☐ Other medication _______________________________(med name) will be stored in the nursing office

We are available to answer any questions or discuss any concerns.

Kind regards,

Victoria Filiatreau, RN
Leslie Graves, APRN
Emily Mills, RN

Sayre Nursing Staff

nursing@sayreschool.org

859-244-2646 (office)

ASTHMA HEALTHCARE PLAN

School Year: __________

Student's Name:_______________________________________**DOB:**____/____/____

Grade: __________ Teacher: ______________________________

Parent/Guardian(1): _______________ Cell: ____________________

Parent//Guardian(2):_______________ Cell:____________________

Doctor:_________________Phone:________________Hospital of Choice:______________

Or call Emergency Contact if unable to reach Parent/Guardian:

*Name:*_________________________________*Phone:*__________________*Relation:* _______________________

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1. Date of student's last asthma episode?____/____/ ____
2. Has student ever been hospitalized for asthma? Yes ☐ No ☐
3. What triggers your student's asthma episodes? (Check all boxes that apply)

   ☐ Pollen ☐ Mold ☐ Dust ☐ Feathers ☐ Animal Dander ☐ Perfume ☐ Air Pollution

   ☐ Smoke ☐ Respiratory Infections ☐ Cold Air ☐ Weather Changes ☐ Vigorous Exercise

   ☐ Foods (Specify) ____

   Other (Specify) ____

4. What are your student's asthma symptoms? (Check all boxes that apply)

   ☐ Coughing ☐ Wheezing ☐ Chest Tightness ☐ Anxiety/Restlessness

   ☐ Difficulty Breathing/Shortness of Breath ☐ Other (Specify) _________________________

5. List the Medication(s) your student takes for asthma:

Name of Medication:	Dosage:	Time of Day:
____________________	__________	__________
____________________	__________	__________

6. List any other Medication(s) your student takes:

Name of Medication:	Dosage:	Time of Day:
____________________	__________	__________
____________________	__________	__________

7. Location of Medication/Inhaler: ____
8. Additional Comments: ____

   ____

*Reviewed by:*_________________________________*RN* *Date:* ____________________

MEDICATION AUTHORIZATION FORM

(Please complete one form for each of your student's medications.)

Student's Name: ____ **DOB:** __________

Allergies: ____

Reason for medication or diagnosis: ____

Medication: ____

Dosage: _______________ **Time of Day to be Administered:** ____________ ☐ **AM** ☐ **PM**

School: ____ **School Year:** __________

In order for school personnel to administer any type of medication to the student, the Parent/Guardian must provide this signed authorization form. Medicine will be dispensed to the student by the School Nurse or by unlicensed school personnel trained and deemed competent by the School Nurse. The medicine must be sent to the school with complete instructions and in the original container with the Physician's Order **OR** pharmacy label firmly attached to the medication.

Please be sure to complete ALL of the information on this authorization form before returning it to school.

Medication to be administered during the school day must be brought to the school by the Parent/Guardian. Parents/Guardians shall pick up unused medication within two (2) weeks of the last day of school or it shall be destroyed. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

The first dose of any new medication should NOT be given at school.

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PARENT/GUARDIAN STATEMENT

I, the undersigned Parent/Guardian of the student named above, request that a ****trained staff member administer*** *the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes.*

☐

*** Parent / Student are responsible to have medication available at school.***

X ____ ____ / ____ / ____

(Parent/Guardian's Signature) Date

Home Phone: __________________ Work: __________________ Cell: _________________

Reviewed by: ______________________________ *RN* *Date:* _________________

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name:____**DOB:**________________

Allergies:____

Medication:____**Dosage:**_________________________

Reason for medication or diagnosis: ____

School Year: ____

In order for students to self-administer medication at school, the Parent/Guardian shall provide this signed authorization form. Also, a Physician's Order (see box below) is required for students to self-administer medication. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

* It is recommended that only middle and high school students are allowed to carry and self-administer their own medication. For elementary age children, arrangements can be made to keep inhalers or emergency medications in the classroom. The student's teacher will provide monitoring for the child's safety.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis) ____ _____
   and have determined that he/she requires medication during school hours.
2. Name of Medication___________________________ .... 3. Dosage & Route: _________________________
4. I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. **Please check: YES NO**

Physician's Signature: ___________________________________ **Date:**_____/_____ / _____

Printed Name: ___________________________________ **Phone:**______________________

PARENT/GUARDIAN STATEMENT

*I, the undersigned Parent(s)Guardian(s) of ______________________________give consent for ****my student to self-administer** the above medication(s). I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.*

The School Nurse reserves the right to monitor student periodically during the school year.

* ***Parent / Student are responsible to have the medication available at school.***

X____ ____/____/ ____

(Parent/Guardian Signature) Date

Home Phone:________________________Work:____________________Cell: ____________________

Reviewed by: __________________________________ RN Date: __________________