BCSD Health Services Asthma Authorization Form 2024-2025

BCSD 5/2023

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT

Student Name:	**Birthdate:**
List **Known Allergies** and/or **Asthma Triggers** include:	
Usual asthma symptoms include but not limited to:	
Prescribed Rescue Medication:	**Spacer Recommended**: No ☐ Yes ☐

Prescribed Frequency and Dose :

☐ As Needed for Rescue Treatment Give _____ Puffs

☐ Before PE/Recess/Strenuous Activity Dose; Give _____ Puffs (Scheduled Doses should be 4 hours apart)

☐ Sick Plan: Scheduled Rescue Treatment Give _____ Puffs every _____ hours and before PE/Recess/Strenuous Activity

It is the responsibility of the parent to notify the school nurse if the student is on a sick plan & for how long.

For Rescue Treatment:

1. Observe student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved.
2. If student is still experiencing breathing difficulties after 20 minutes:
   IT IS ☐ **or** IS NOT ☐ okay to repeat rescue treatment dose for up to a total of _____times to relieve breathing difficulties.

Daily Asthma Control Medication(s) prescribed for **at home** use**:**

Student has permission to self-carry / self-administer this medication: ☐ **No** ☐ **Yes – if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ Phone: _____

Health Care Provider Signature:_____ **Date**: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).

. ***My student has orders from our health care provider to Self-Carry/Self-Administer this medication:***

☐ ***No*** ☐ ***Yes *If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Beaufort County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name: _____Daytime Phone Number: _____

Parent/Legal Guardian Signature: _____**Date**: _____

This form is only valid if signed on or after July 1st for the upcoming school year.