PARENTS
IMPORTANT
NEW INFORMATION
Regarding Students Being Permitted to Self-administer Asthma Medication

Effective July 1, 2002, the GCPS policy has been updated to reflect the current Georgia law allowing that a student who has asthma may possess and is permitted to self-administer, at his/her discretion, asthma medication prescribed for him/her by his/her physician. The student will be allowed to self-administer asthma medication while at school; at a school sponsored activity; while under the supervision of school personnel; or during before school or after school care on school operated property.

The following conditions apply in order for a student to possess and self-administer asthma medication:

1. The parent or legal guardian must notify the school in writing that the student has asthma and will possess and self-administer asthma medication. The school *will accept this notification on the GCPS Medication Administration Form* that can be obtained from the local school clinic.
2. The school must be *notified in writing by the student's physician.* The school will accept this notification in the form of a letter signed by the physician on the physician's stationery, the physician's prescription pad paper, or the signature of the physician on the GCPS Asthma Action Plan. The GCPS Asthma Action Plan can be *obtained from the local school The notification from the physician must include:*
    a. *A statement that it is necessary for the student to possess and self-administer asthma medication.*
    b. *The name and the appropriate dosage of the asthma medication.*
    c. *A statement that the student has been properly trained by the physician as to the use of the asthma medication.*

ASTHMA MANAGEMENT PLAN
SCHOOL YEAR:

STUDENT: **BIRTHDATE:**
SCHOOL: **STUDENT ID:**

MOTHER:	**FATHER:**	
HOME PHONE:	**HOME PHONE:**	
WORK:	**WORK:**	
CELL:	**CELL:**	
EMERGENCY CONTACT:	**PHONE:**	
PHYSICIAN:	**PHONE:**	**FAX:**

MEDICATIONS TAKEN AT HOME:		
Medication Name:	**Dose:**	**Time:**

SCHOOL MANAGEMENT OF ASTHMA:

GREEN ZONE- GOOD	**YELLOW ZONE- CAUTION**	**RED ZONE-DANGER**
If student has ALL of these: • **Breathing is easy** • **No Cough or wheeze** • **Can play and work** **NO TREATMENT NEEDED** **If in GREEN ZONE BUT <u>EXERCISE</u> MAY CAUSE ASTHMA SYMPTOMS, USE:** Use_____ **(name of medication)** _____ puffs _____ minutes before exercise	**If student has ANY of these:** • **First sign of a cold** • **Cough or mild wheeze** • **Tight chest** • **Problems with work or play** □ **Use _____,** **(name of medication)** **_____ puffs inhaler every _____ hours as needed** **OR** □ **Use _____,** **(name of medication)** **_____ nebulizer treatment every _____ hours as needed** □ **Other treatment needed:** _____ _____	**If student has ANY of these:** • **Can't talk, eat, or walk well** • **Medicine is not working** • **Breathing hard and fast** • **Blue lips and fingernails** • **Tired or lethargic** • **Skin around neck and ribs pulls in** **Call 911 then contact parent.**

<u>This section is to be completed by a **Physician** IF</u> student is to possess and self-administer medication in school at a school sponsored activity; while under the supervision of school personnel; or before, during, or after school care on school operated property, (in compliance with SB 472, effective 7/01/02).

<u>FOR INHALED MEDICATIONS:</u> (Please check one of the options below)

1. _____I have instructed this student in the proper use and dosage of his/her inhaled medication. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself.
   <u>OR</u>
2. _____This student is <u>not</u> approved to self-medicate.

_____ _____
Physician Signature Date

School Clinic: Copy of this plan should be provided to Transportation Supervisor

_____ _____
Parent Signature Date County School Nurse Signature Date

Confidentiality of student health information should be maintained at all times.

Rev. 12/2015

Authorization for Student to Carry a Prescription Inhaler, EpiPen® or Insulin

_____ _____ needs to carry the following prescription labeled inhaler, EpiPen® or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, EpiPen® or additional insulin be kept in the clinic in case the first is lost or left at home.)

_____

Medication Dosage and Directions

_____

Physician's Signature or Stamp Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

_____

Student's Signature Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen; the privilege of carrying the medication may be revoked. I release the school district and its employees of any legal responsibility when the above named student administers his/her own medication.

_____

Parent/Guardian Signature Date