



Individual Health Plan Sch year__ GR__RM__

Asthma-Medication at School

Completed by Health Care Provider (Needs to be updated each school year)

Name

Birth Date:

Triggers (circle all that apply): Dust Chemical odors Pollen Mold Animal Dander Upper Respiratory Infections Cold Air Exercise Smoke

Food: _____

Other: _____

Symptoms: *can change quickly and rapidly progress to a life-threatening situation!*

- **Mental:** anxious
- **Respiratory:** chest/neck retracts when breathing, cough wheezing breathless tightness in chest
- **Skin:** pale around the mouth

THIS STUDENT'S ASTHMA IS LIFE THREATENING

☐ YES (Rescue Med/Tx may be Required)

OR

☐ NO

Action Plan: *If sending student anywhere, send with an escort or call office for assistance*

Basic Management	Call 911 if:
<ul style="list-style-type: none">• Stay calm and stay with student• Have student use inhaler, per Health Care Provider Order's• Have student drink warm water• If improvement takes place, student may return to class. If no improvement, call parent.	<ul style="list-style-type: none">• Chest/neck retracting when breathing• Student is hunched over• Student is struggling to breathe• Blue lips or fingernails• Difficulty walking or talking• No improvement 15 minutes after using inhaler• No audible lung sounds
Further recommendations from HCP: (classroom, school bus, field trips, disaster etc.)	

Name of Medication(s) needed at school	Dose	Time of day to be given

I request and authorize this student to carry their medication/self-administer. (7-12 grade carry for sports)

They have demonstrated proper use in my office. Yes ___ No ___ PCP initials ___ School Nurse initials ___

Health Care Provider Signature:

Health Care Provider Name (print or type):

Phone:

Fax:

School Nurse Signature:

Date:

Parent Permission (to be completed by parent or guardian)

- By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the administration of medication by the KSD staff or as self-administered by the student.
- Parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication.

Signature of parent or guardian: _____ **Date:** _____

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed oral, nasal spray, topical, eye drop or ear drop medication and over-the-counter oral, nasal spray, topical, eye drop or ear drop medication should be dispensed before and/or after school hours under supervision of the parent/guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed health care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Authorization for Mutual Exchange of Confidential Information

Purpose: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		To:	
Agency/Person: _____	Agency/Person: _____	KSD Nurse	
Street Address: _____	Street Address: _____		
City, State, Zip: _____	City, State, Zip: _____	Kennewick, WA,	
Tel: _____	Fax: _____	Tel: 509-222- _____	Fax: 509-222- _____

Describe records to be disclosed: **Diagnoses, medication, medical recommendations applicable for student at school.**

The reason for disclosing the record(s) is: **To provide safe care of the student in the educational setting**

This authorization is valid from: ____/____/____ to: ____/____/____.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature: _____

Date: _____