

Dear Parents/Guardians

If Asthma medication(s) is required for administration for the next school year (August 2025- June 2026) please remember to follow these important steps:

Medical Orders must be written and dated after July 1st, 2025. Medical orders are only active for the current school year.

- Medical providers must provide **medication orders** that include the name of the medication, form of medication (inhaler, solution) frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.
- Medical providers must provide **(1.) Asthma Action Plan (2.) Please review and sign with a medical provider the Emergency Action Plan for campus non-medical staff when a nurse is not on campus/after school activities/field trips and bus drivers.**
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- Please bring medications to school before the first day of classes. They must be in the original pharmacy packaging with your student's name on it and non-expired. **You may call the Health Office after August 20, 2025, to arrange a drop-off.** No student is allowed to carry any medications to school, even over-the-counter medications.
- Please review the AMSACS medication administration policy.
- **No Student will be allowed to attend a class field trip until their asthma paperwork is completed, and the student has brought their inhaler to the Health Office prior to the event**

PARENT/ GUARDIAN MEDICATION CHECK LISTS

Checklist for Required Paperwork for Metered Dose Inhalers/ Nebulizer Solution

Documents from your medical provider needed:

1. _____ Medical Order Form
2. _____ Asthma Action Plan/ Health Care Plan for School
3. _____ Sign the Asthma Emergency Action Care Plan for Non-Medical Staff/ Bus Driver/After School Activities

Parent to Complete:

1. _____ Parent's Permission for Metered Dose Inhaler/ Solution Administration
2. _____ Inhaler Contract to Carry if applicable
3. _____ Sign the Asthma Emergency Action Care Plan for Non-Medical Staff/Bus Driver/After School Activities

Please be aware that if you feel your child has needs beyond the medical provider's plans you may call Guidance for a 504 Plan

If you need this information translated, please copy and paste it into Google Translate. The link to Google translate is <http://translate.google.com/>

Advanced Math and Science Academy Charter School

Parent/Guardian Permission/ Medication Administration Plan (MAP) for Asthma Medication 2025-26

Student: _____ DOB: _____ Grade: _____ Name of Licensed Prescriber: _____ Phone Number: _____ Emergency Contact; Name/Number: _____ _____	Parent/Guardian Name: _____ Home Phone: _____ Cell Phone: _____ Parent/Guardian Name: _____ Cell Phone: _____
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Name of Medication: _____ Date of Medical Order (received after July,1, 20025) _____

Diagnosis: _____ Duration of Medication (Start Date/ End Date): _____

Allergies to Food or Medication:()Yes ()No Specify Allergy: _____

Other medication being taken by my student (if not in violation of confidentiality): _____

() I give permission for my child to self- administer this inhaler/medication, if the school nurse determines it is safe and appropriate.

Possible Side Effect/Adverse Reactions- Plan for monitoring student after Admin if needed: _____

*******If a student needs to use their inhaler at school, we ask them to report to the Health Office for a pre and post evaluation.**

****** If the student will be self-carry, please fill out second page "Contract to Carry and Self Administer Inhaler (MDI)"**

How do you want to handle asthma medication administration during times when your child is attending a school function/event, after school hours (clubs/sports, etc.), during off school activities during day/overnight field trips? (Please check one only)

- a. COP (Carries on Person at all times)
- b. FTAS (Carries only on field trips and after school activities)
- c. DNC (Does not carry- Chaperone to carry and be with student during entire event)
- d. Parent to attend field trip/activity

() I understand that a parent/guardian must drop off medication to the school nurse and it must be in it the original pharmacy packaging with student's name and the appropriate label.

() I give permission to the school nurse to administer the above medication to my child in accordance with their medical orders and Asthma Action Plan.

() I give permission to the school nurse to share with appropriate school personnel the information related to the prescribed medication as deemed necessary for my child's health and safety.

() I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

*******Please be aware that there is no availability for medication administration during after school activities other than staff is trained for EpiPen administration**

Parent/Guardian Signature: _____ **Relationship to Student:** _____ **Date:** _____

FOR HEALTH OFFICE USE ONLY: School Nurse Signature: _____ Date: _____

Name of Inhaler(med.): _____ Date of Medical Order (received after July 1, 2025): _____ Required Storage :() Unlocked; labeled Inhaler () COP

Duration of Med. (Start Date/End Date): __/__/__ Quantity of Med. Received and Date _____ Expiration Date on Inhaler: _____

Dosage: _____ Frequency: _____ Specific Time: _see medical order_ Route of Administration: _____

Disposal of medication: () Finished ()Returned to parent/Guardian ()Given to Student Nurse's Signature: _____ Date: _____

()Disposed/Witness: _____ Date: _____

******* Attach Medical orders & Medical Care Plan for School*******

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Attach student Photo:

Contract for Permission to Carry and Self-Administer Inhaler (MDI) 2025-26

Name of Student: _____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their metered dose asthma rescue inhalers with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. Please sign at the bottom of this form below and return it to the health office. The school nurse and your child will complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication while on this field trip only. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement.

Parent/Guardian Signature: _____

Date: _____

Is Pre-Physical Education Administration required? Yes No

CONTRACT AGREEMENT: Check One

- COP (Carries on person at all times) FTAS (Field Trips/Sports/ After School Activities)
- DNC (Does Not Carry. Chaperone/coach/club leader carries, and student is to be with them for duration of event)
- Other to be determined by Sch. Nurse: _____

To be completed by School Nurse and Student

Medical order for this medication is on file in the Health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administered and purpose of the medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student demonstrates safe and correct use /administration of medication and agrees to carry only the amount of medications required. Amount of medication student can carry is one MDI	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to be responsible to <u>provide and carry his/her own MDI on field trips/after school activities/clubs/sports</u> . If student forgets to bring his/her MDI, & there is no backup in H.O. they will not be allowed to attend a field trip.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering this medication, on field trips/sports/club activities he/she will immediately inform the field trip chaperone/club leader/sports coach etc. of administration.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees NEVER share the medication(s) with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering inhalation medication, if there is no marked improvement, he/she will immediately see the School Nurse or seek medical attention	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to self-administer MDI in health office. If MDI use is used during school hours at Forekicks, Student agrees to come to health office to report date and time of self-administration.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to maintain a backup Metered Dose Inhaler in the health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Expiration date on Medication in Health Office is _____		
Expiration date on Medication student is carrying is _____		

I give permission to notify staff of my plan for self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: _____

Date: _____

This student does does not demonstrate the required responsibilities. This student may may not carry/self-administer the medication. This student may self-administer their MDI prior to/during Phys. Edu. Yes No

Nurse Signature: _____

Date: _____

Student: _____	Parent/Guardian Name: _____
DOB: _____ Grade: _____	Home Phone: _____
Name of Licensed Prescriber: _____	Cell Phone: _____
Phone Number: _____	Parent/Guardian Name: _____
Emergency Contact; Name/Number: _____	Cell Phone: _____

Medication/Inhaler Student Uses: _____

When (signs & symptoms) should a student use their inhaler: _____

Know the Signs & Symptoms of Asthma attack/breathing difficulties:

- Excessive or prolonged coughing, difficulty breathing, wheezing and/or sensation of chest tightness or pain
- Difficulty speaking
- Frightened facial expression
- Flaring of nostrils
- Loss of color in lips, bluish tinge to fingernails

1. Never leave the student alone if he/she is having trouble breathing
2. Allow students (COP) to administer their quick acting inhaler that's been prescribed to them.
3. Remain with the students, having them rest in seated position, breathing slowly through their mouth, exhaling slowly through pursed lips. Speak calmly and reassuringly.
4. Then send the student to the Health Office; from Forekicks if unable to walk - walkie the Health Office and send inhaler with student

EMERGENCY PROCEDURE:

1. If a student has any signs or symptoms of a severe asthma attack or breathing difficulties- call the **Nurse x2475/2409/2472** who will provide emergency care.
2. **Call 911** (from a landline if possible) if unable to reach a Nurse and initiate EMS if student is not breathing, is unconscious; lips are blue; struggling to breath or other signs of significant distress.
3. If a student is experiencing mild asthma symptoms, send them to the Health Office with a responsible student or adult. Never send a student to the Health Office alone if they are experiencing any signs or symptoms of asthma or difficulty breathing.
4. A nurse will notify parents.

If you want additional care given, describe action here:

Physician Signature _____ **Print Name:** _____ **Phone:** _____ **Date:** _____

- I want this plan implemented for my child, _____, in school. I hereby give my permission for the exchange of confidential information contained in the record of my child between the School Nurse and Medical Provider; my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

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

Attach Student Photo:

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