

**OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM**

ASTHMA ACTION PLAN

9020.05F

PHYSICIAN/PARENT AUTHORIZATION (INHALER KEPT IN OFFICE)

Student: _____ Grade/Teacher: _____ DOB: _____

List routine, daily meds taken to control ASTHMA/Allergies: _____

Medical Condition - **ASTHMA:** Controlled Chronic Acute when ill Seasonal

MEDICATION ADMINISTRATION –PHYSICIAN AUTHORIZATION

ADMINISTER INHALER/Medication _____, _____ PUFFS every _____ hour.

This medication is to be administered under what special conditions: _____

INHALER WILL BE STORED IN SCHOOL OFFICE.

Physician Name/Phone: _____ / _____

Physician Signature: _____ Date: _____

TRIGGERS, SYMPTOMS AND INTERVENTIONS

Check Triggers: Exercise Animals Cold Weather Molds Respiratory Illness Chalk Dust
 Pollen Odors Perfumes Trees/Grass Latex Food: _____

Check Symptoms: Coughing Wheezing Labored/Difficulty Breathing Other: _____

Nebulizer Inhalation Therapy: YES NO

If YES, Parent provides all equipment including clean tubing, nebulizer and medications with prescriptive label.

DAILY/Frequency _____ When Symptomatic _____ Other _____

Medication #1 (*Name and Dosage*): _____

Medication #2 (*Name and Dosage*): _____

Time of day to administer if daily: _____

Potential side effects: _____

In the event of a crisis requiring immediate intervention, a trained school employee will administer the *prescribed* medication. The undersigned understands that the employee administering the *prescribed* medication may not be a licensed healthcare professional. The undersigned hereby consents to the intervention of the employee under these circumstances. The undersigned agrees to hold the Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from medication administration and emergency care unless injury was caused by the employee's negligence.

Parent/Guardian hereby gives consent for the child's medical records and reports to be shared with the Oldham County Board of Education and its employees, and for the child's physician to discuss his or her medical condition referenced above with school or District personnel to assist them in planning for my child's care while at school or school events.

Signature of Parent/Guardian

Date

Cell Phone:

Work Phone

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PHYSICIAN/PARENT AUTHORIZATION for SELF CARRY/ADMINISTRATION

Student: _____ DOB: _____

School/Grade: _____ Current Age: _____

**PHYSICIAN AUTHORIZATION for SELF-ADMINISTRATION BY STUDENT
Physician and Parent/Guardian Signature required per KRS 158.834**

Diagnosis – **ASTHMA:** Controlled Chronic Acute when ill Seasonal

Medication/Inhaler: _____ Dosage: _____

- This student has been instructed by PHYSICIAN regarding the care, storage and use of this prescribed medication and has the ability to determine appropriate administration of the medication. The medication must be carried on the student's person and will be labeled with the student's name.
- This student had been instructed by PHYSICIAN that if symptoms are not relieved by medication administration, STUDENT must notify a school staff member or other supervising adult immediately.

Printed Name of MD, DO, ARNP or PA

FAX number

Signature of MD, DO, ARNP or PA

Telephone

Date

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION BY STUDENT

Signing this form shall release Oldham Co. Board of Education and its employees from liability for any injuries resulting from your student carrying, maintaining, and self-medicating. Parent/guardian agrees to hold harmless OCBE employees from any claim resulting from student's self-administration of medication to treat Asthma per state law KRS 158.834. Parent/Guardian gives consent to Oldham County Board of Education employees to discuss the medical condition referenced above with physician to assist in planning for the student's care while at school or school events. Permission for self-administration of medication shall be effective for the school year in which it is granted by Physician and Parent and shall be renewed each following school year.

Parent/Guardian of _____ AGREES that it is the responsibility of the parent/guardian to require the student to be in possession of the above prescribed medication during the school day, extracurricular activities and during field trips. Replacement of expired medication is the responsibility of the parent/guardian.

Signature of Parent/Guardian

Home Phone and Cell

Date

Emergency contact:

Phone:

Relationship:

EMERGENCY PLAN OF ACTION for STUDENTS WITH ASTHMA

- 1. CALL EMS 9-911** if wheezing or coughing has not improved after medication administration by student; student is having difficulty breathing; student has trouble walking or talking; student's fingernails, lips or gum line (darkened) are blue/ashen; student has any of the above symptoms and does NOT have access to medication documented above.
- 2. NOTIFY** school personnel trained in CPR/AED to care for student and initiate CPR/AED if needed prior to EMS arrival. Notify parent/guardian or emergency contact. If student is transported via EMS, a school staff member must accompany student.