SCS
SCOTT COUNTY SCHOOLS

Dear Parent/Guardian:

According to our health records, your child has a history of asthma that my require having an inhaler on hand for possible asthma attacks.

Enclosed are the forms that need to be completed by the Parent/Guardian and/or Physician and returned to the School Nurse. We **must** have the medication form along with the inhaler so that staff may use the inhaler in case of an emergency. Even if your child self-carries his inhaler, we must have the proper paperwork so that staff can assist him in the administration in an emergency. Please be sure the physician indicates on the medication form if this medication can be self-carried.

This information on these forms will help us determine how best to help your student during the school day and will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following forms need to be completed and returned to your child's school at the start of the school year.

- Administration of Medication Form (parent and physician)
- Asthma Individualized Health Plan (parent)

Please contact the School Nurse if you have any questions.

We are looking forward to a great year with your student!

Scott County School District Nurse

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# Management of Students with Asthma Guidelines

**SCOTT COUNTY SCHOOLS** are committed to fully meeting the needs of pupils who have asthma, keeping them safe, ensuring they achieve to their full potential, and are fully included in school life. This may include

- Keeping careful records of changes in behavior and levels of achievement to identify pupils who are not achieving to their full potential.
- Ensuring that all pupils with asthma are fully included in school life, activities and outings (day and residential) and are not isolated or stigmatized.
- Giving voice to the views of pupils with asthma, for example regarding feeling safe, respect from other pupils, and what should happen during and following an asthma attack.
- Liaising fully with parents and health professionals (with the parent's permission) to share information about the pupil's education, healthcare, medication and any affects this has on their school life.
- Ensuring that staff are asthma aware and know what to do if a pupil has an asthma attack or asthma symptoms.
- Ensuring that there will be a trained member of staff available at all times to deliver/assist with rescue inhalers.
- Every student with asthma will have an Individual Health Care Plan/ Asthma Emergency Action Plan in place, which will include information on the pupil's asthma, triggers, medication, and emergency protocols.

**PARENTS/GUARDIANS** are expected to be an active liaison for their child by:

- Notifying the school of your child's asthma diagnosis or any changes in his/her diagnosis.
- Filling out and returning the Medication Administration Form and Individual Health Care Plan/Asthma Emergency Action Plan.
- Providing medical information from a District-approved recognized medical authority (RMA) authorized to practice within the State of Kentucky as noted in the student's IEP, 504 plan, or health plan.
- Providing updated medical information as requested by the District.
- Participating in any meetings or discussions regarding the child's health plan.
- Notifying the school of any changes relating to his asthma.

8/21/25

# Individualized Health Plan / Emergency Action Plan
## Asthma / Inhaler *(side one)*

Student _____ Date of Birth: _____
School _____ School Year _____

**Triggers** (Check all that apply to this child)

____Exercise ____Animals
____Fumes ____Carpet
____Strong Odors ____Pollen
____Molds ____Respiratory Infection
____Chalk Dust ____Change in Temperature
____Trees/Grass/Shrubbery
Foods (Specify) _____
Other (Specify) _____

**Signs and Symptoms** student will likely exhibit (Check all that apply)

***Note: Parent/Guardian will be contacted if symptoms persist**

____Coughing ____ Wheezing ____ Labored/Difficulty Breathing
Other (Specify): _____

**Recommended Preventative/Interventive Measures** (Check all that apply)

*Encourage student to assume position of comfort
*Offer warm liquid to drink
* Encourage slow, even breaths

*Nebulizer / Inhaler (circle one) - Medication via the nebulizer/inhaler will be given at school as follows:

Medication (Name and Dosage): _____
Time of day to administer _____
____On a daily basis ____As needed
Reaction or Side effects: _____
Comments _____

*This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own.*

____Yes* ____ No

***If yes, please note: Student will be expected to carry and use his/her inhaler responsibly.**

**Emergency Plan of Action**

* If color becomes pale, cyanotic (bluish), or ashen Call EMS (9-911)
* If breathing stops CPR certified staff should initiate rescue breathing (and CPR if necessary)
* Contact parent/guardian or emergency contact immediately

*

_____ _____ _____
Emergency Contact Telephone No Relationship

*

_____ _____ _____ _____
Printed Name of MD, ARNP, or PA Address Telephone No

Other (Specify) _____

Do you want your child's inhaler transported on the bus between home and school? _____ YES _____ NO
(If marked yes, remember it is the parent's responsibility to make sure the inhaler is sent with the child daily)

_____ _____
Signature of Nurse Date

See back of page for details of medication administration

# Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

**Student's Name:** _____ **Grade:** _____ **Homeroom/Classroom:** _____

**Student's Age:** _____ **Date of Birth:** _____

**TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") MEDICATION**

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Restrictions and/or important side effects: ☐ No restrictions/side effects ☐ Yes. Please describe:

_____

**NOTE:** ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

*Pursuant to KRS 158.832 to 158.836, Scott County Schools permits a student to possess and self-administer medications for asthma, diabetes, or anaphylaxis at school and at school-related function upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.*

Student has been instructed in self-administering the medication to be completed for asthmatic, diabetic, or severe allergic reactions (anaphylaxis) ONLY: ☐No ☐Supervision Required ☐ Supervision Not Required

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

***Physician/Health Care Provider Signature*** ***Date***

_____ _____

***Signature of Parent/Guardian*** ***Date***

**Name of Physician/Health Care Provider:** _____

**Address:** _____

**Phone #:** _____ **Fax #:** _____

**To the school:** Please report concerns about medications or the student's condition to the above physician/health care provider.

SCHOOL PERSONNEL: PLEASE ENSURE PAGE 2 OF THIS FORM IS ALSO COMPLETED.

# Permission Form for Prescribed or Over-the-Counter Medication

**FOR ALL MEDICATIONS**

I give permission for _____ to receive the above medication(s) at school according
***Student's Name***
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

*Date:* _____ *Signature:* _____ *Relationship:* _____

*Home Phone:* _____ *Work Phone* _____ *Emergency Phone* _____

**TO BE COMPLETED BY SCHOOL PERSONNEL**

I/we acknowledge receipt of the foregoing statement and authorization.

***Administrator/designee*** _____ Date _____