Lake Elsinore Unified School District
Health Services

Pupil	DOB	School	Grade

Health Care Provider's and Parent's Written Authorization for Asthma Management (please check all boxes that apply)

☐ **Medication At School:**
Medication_____
Dose _____
Frequency _____

*****In order for student to carry inhaler on his/her person, page 2 of this form must be completed*****

☐ **Nebulizer At School**:
Interval after use of rescue inhaler before nebulizer may be used:
_____

Medication_____
Dose_____
Frequency_____

Medication_____
Dose_____
Frequency_____

☐ **Activity restrictions** (Please check all that apply)
- ☐ No restriction
- ☐ Activity as tolerated
- ☐ Student to set own limits
- ☐ Restrict activity if temperature > _____ or < _____
- ☐ Other_____

Peak flow monitoring
- ☐ Not required
- ☐ Prior to administering MDI or nebulizer treatment
- ☐ Prior to P.E. or recess
- ☐ Only if symptomatic

Green Zone: _____ to _____
Action: _____

Yellow Zone: _____ to _____
Action: _____

Red Zone: _____ to _____
Action: _____

Other Needs (Specify):

Parent Consent For Asthma Management In School

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above Asthma Management Plan be implemented for my child in accordance with California Education Code Section 49423. I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending health care provider
3. Notify the school nurse immediately and provide new authorizations for any change in doctor's orders

I authorize the school nurse to communicate with the health care provider regarding any questions that may arise with regard to the above Asthma Management Plan. ***If your health care provider would like your child to carry an inhaler on his/her person, page 2 of this form MUST be completed by the health care provider, parent, and child.**

Parent/Guardian Signature _____ **Date** _____

Health Care Provider Authorization For Asthma Management In School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code Section 49423. I understand that unlicensed designated school personnel under the training and supervision of the school nurse may perform specialized physical health care services. This authorization is for maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Health Care Provider Name (Please print) _____ **Phone** _____

Signature _____ **Date** _____

Address _____ **City** _____ **Zip** _____

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

REVIEWED AND APPROVED BY DISTRICT NURSE:_____
Nurse signature **Date**

Lake Elsinore Unified School District
Health Services

Student Name	DOB	School	Grade

In order for your child to carry a self-administered emergency medication (asthma inhaler) on his/her person, the following must be understood and agreed upon by the student and parents: the student may utilize the prescribed self-administered medication as needed and directed by his/her health care provider. The health care provider's signature indicates the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name**.** ***Both the Authorization for Asthma Management form (page 1) and this Protocol (page 2)*** must be signed by the parent/guardian and placed on file at the school prior to your child carrying an inhaler on his/her person.

Inhaler: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues having difficulty breathing, he/she should report to the health office and the parents will be notified by the appropriate school staff.

- It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in health care provider and/or medication occurs. Changes in procedure must be received in writing from the health care provider authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/her or the students on campus.

PERMISSION TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION (i.e. inhaler)

TO BE COMPLETED BY HEALTH CARE PROVIDER: The above-named student has been instructed in the proper use of their asthma inhaler. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler at school. He/she is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the emergency medication.

HEALTH CARE PROVIDER'S SIGNATURE:_____ DATE: _____

PRINTED/TYPED NAME OF PROVIDER:_____ PHONE:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed emergency medication as ordered by his/her health care provider. I also specifically release the school district and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

TO BE COMPLETED BY THE STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other than as prescribed by my doctor can result in disciplinary action taken against me by my School/District.

STUDENT'S SIGNATURE:_____ DATE: _____

REVIEWED AND APPROVED BY DISTRICT NURSE:_____

Nurse signature **Date**

Please return the fully completed forms to your child's school health office signed by the health care provider, parent/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instructions.

NO MEDICATION WILL BE ALLOWED WITHOUT THE REQUIRED SIGNATURES

Form 7127 Rev. 3/22