# FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT HEALTH SERVICES

## AUTHORIZATION FOR THE ADMINISTRATION OF ASTHMA MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR FOR EACH MEDICATION

POLICY GOVERNING THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
Board Policy 5141.21

*The Governing Board recognizes that some students may need to take medication prescribed by a physician during the school day in order to be able to attend school. The Superintendent or designee shall develop processes for the administration of medication to such students by school personnel*

BASIC LEGAL PROVISION-California Education Code, Section 49423; 5 CCR 600

*Prescribed medication may be administered by the school nurse or other designated trained school personnel only when the Superintendent or designee has received written statements from both a student's physician and parent/guardian.*

**PARENT REQUEST FOR ADMINISTRATION OF MEDICINE PRESCRIBED BY A PHYSICIAN**

Student's Name _____ Birthdate _____ Grade _____School _____

My child will need to take prescription medication during school hours. I understand that prescription medication shall be brought to the school office in the original container(s) and labeled with my student's name.

*We the undersigned, who are the parents/guardian of _____ request that a designated member of the school staff, in accordance with instructions administer medicine during school hours to said child in accordance with the instructions outlined below and signed by our physician.*

*In agreeing to have the school administer our son's/daughter's medication, I voluntarily agree to release, discharge, and hold harmless Folsom Cordova Unified School district and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes our child's illness, injury, death, and damages of any nature in any way connected with the administration of our child's medication.*

*We understand that the major responsibility for a child taking medication rests with the child and his/her parents or guardian and that we are required to personally bring the medication to school (preschool through 5th grade). With the exception of controlled substances, we understand that students in grades 6 through 12 may bring their own medication to the school office.*

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

**Parent's name (please print)**: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact: _____ Phone: _____

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**PHYSICIAN'S INSTRUCTIONS - Please note**: School Nurses are not always available on the school campus. Whenever possible please prescribe medication that can be given outside of the school day. If medication **must** be administered during school hours, please complete the information below:

Asthma Severity: _____ Triggers: _____

Medication: _____Method or Route of Administration: _____

Dosage: _____ puffs, every _____ hours as needed OR _____ puffs at _____(time)

Length of Time to be Taken: ☐ School Year ☐ Temporary: Start Date: _____ End Date: _____

Physician's Instructions/Possible side effects of medication: _____

_____

Will student need to personally carry this medication? Yes ☐ No ☐ (may not carry controlled substances)

Will student be "self-administering" this medication? Yes ☐ No ☐ (excluding controlled substances)

| Green Zone: Looks Good | Prevent asthma symptoms everyday: |
|---|---|
| • Breathing is good<br>• No cough, wheeze, chest tightness or shortness of breath<br>• Can work or play like normal | ☐ 10-20 minutes before exercise, give quick relief medication ___ puffs with spacer (if available); repeat in 4 hours for additional or ongoing exercise |
| ***Yellow Zone: Looks Worse than Usual*** | ***DO THIS:*** |
| • Difficulty breathing<br>• Frequent cough<br>• Complaining of chest tightness<br>• Unable to tolerate regular activities but still able to talk in complete sentences<br>• Waking at night due to asthma symptoms | Give QUICK RELIEF medication ___ puffs right NOW<br>• Wait with student for 15-20 minutes; if symptoms not better, repeat the dose and wait 15-20 minutes<br>• If **NOT** back in the Green Zone after 2nd dose of medication, **go to the RED ZONE**<br>• If symptoms return to the Green Zone, wait 15 minutes and return to class continuing to use the quick relief medications ___ puffs every ___ hours<br>• Call parent/guardian to inform them of need for quick relief medication today |
| **RED ZONE: EMERGENCY SITUATION – Get Help!** | **DO THIS IMMEDIATELY** |
| • Coughs constantly<br>• Struggles or gasps for air<br>• Trouble talking (can only speak 3-5 words at a time)<br>• Skin/muscles of chest or neck pulling in with breathing<br>• Blue lips or fingernails<br>• Drowsy or confused | Give QUICK RELIEF medication ___ puffs right NOW<br>• **Call 911 immediately; do not leave the student**<br>• Wait with student and repeat the above dose every 10-15 minutes until paramedics arrive<br>• Call parent/guardian and school nurse<br>• Refer to anaphylaxis plan if student has allergy |

**Physician's Signature**: _____ **Date** _____

**Physician's Name (Please Print)**: _____

**Address:** _____ **Office Phone:** _____ **Fax Number:** _____

| **Monday** | | | **Tuesday** | | | **Wednesday** | | | **Thursday** | | | **Friday** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | Time | Init. | Date | Time | Init. | Date | Time | Init. | Date | Time | Init. | Date | Time | Init. |
| ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
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| ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |

**RX Confirmed : 5 Checks** **RN** _____ **Date** _____