School Year: _____

Model Laboratory School

SCHOOL HEALTH DIVISION
521 Lancaster Ave.
Richmond, Kentucky 40475
(859) 622-8575
fax: (859) 622-6658

ASTHMA PARENT PACKET

Dear Parent/Guardian:

Please fill out the attached asthma information and return it to your School Nurse. It will be shared with appropriate persons such as your student's classroom teacher and physical education teacher. Your comments and instructions will help us to assist your student during asthma episodes as well as to minimize restrictions.

According to Model Laboratory School Medication Policy, **ALL** medications, including inhalers, are to be stored in a secure location and students are to be supervised by school staff when taking them. The purpose of this policy is to assure safe use of all medication, to prevent errors, and to prevent children from sharing their medications with others. The school staff is required by policy to be responsible for safe and supervised medication administration to students, except as noted below.

Students are allowed to carry their inhalers if the following conditions are met:

- **It has been determined that student is socially, cognitively, physically, and emotionally mature enough to carry and administer the inhaler.**
- **Parent and Physician Authorization Forms are completed and on file at school.**

When students self-administer medication the school staff will NOT be responsible for monitoring frequency of use, expiration date, or amount of medication available for use.

Please send a current picture of your student in order for the student to be easily identified. This information 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 phone numbers.

The following need to be returned to the School Nurse at your school:

- **Asthma Healthcare Plan**
- **Medication Authorization Form**

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

Please call School Health Services at 859-622-8575 if you have any questions.

ASTHMA HEALTHCARE PLAN

School Year: _____

MEDICAL CONCERN: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____ **DOB:** ___ / ___ / ___

Allergies: _____

School: _____ Teacher: _____ Grade: ____

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Doctor: _____Phone #: _____ Hospital of Choice: _____

Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Or call Emergency Contact if unable to reach Parent/Guardian:

Name: _____ *Phone:* _____ *Relation:* _____

****

1. Date of student's last asthma episode? ___ / ___ / ___
2. Has student ever been hospitalized for asthma? Yes ☐ No ☐
3. What triggers your student's asthma episodes? (Check all boxes that apply)

   ☐ Pollen ☐ Mold ☐ Dust ☐ Feathers ☐ Animal Dander ☐ Perfume ☐ Air Pollution

   ☐ Smoke ☐ Respiratory Infections ☐ Cold Air ☐ Weather Changes ☐ Vigorous Exercise

   ☐ Foods (Specify) _____

   Other (Specify) _____
4. What are your student's asthma symptoms? (Check all boxes that apply)

   ☐ Coughing ☐ Wheezing ☐ Chest Tightness ☐ Anxiety/Restlessness

   ☐ Difficulty Breathing/Shortness of Breath ☐ Other (Specify) _____
5. List the Medication(s) your student takes for asthma:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

6. List any other Medication(s) your student takes:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

7. Location of Medication/Inhaler: _____
8. Additional Comments: _____

   _____

Reviewed by: _____ *RN* *Date:* _____

Madison County School District School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age: _____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PARENT / GUARDIAN

************(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)************

Name of medication: _____Reason for medication:_____

ALLERGIES:_____ Any OTHER Condition(s):_____

Form of medication/treatment:_____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school:_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:_____

Parent or Guardian Signature_____Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:_____Signature:_____ Relationship:_____

Home phone:_____ Work phone:_____ Emergency or CELL phone:_____

TO BE COMPLETED BY Health Care Provider

♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY♦♦♦

This student is capable, responsible, and demonstrated self-administration of the above medication:

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):_____**

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (7-2014)**

Adapted from the Academy of Pediatrics