MEDICATION ORDER TO CARRY ASTHMA INHALER

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY PRESCRIBED MEDICATION

For online forms: http://sbo.nn.k12.va.us/healthservices/medications.html

These requests are exceptions to School Board policy JLCD and must be approved.

1. Parents will submit the following forms:
   a. Request for Approval for Students to Carry Prescribed Medication
      (completed by parent)
   b. Completed Asthma Action Plan and Authorization for Medication form
      (completed by medical provider)
   c. Responsibilities of Student and Parent Requesting Exception to Rule 3
      (MEDICATION) and Rule 26 (ALCOHOL AND OTHER DRUGS)
   d. Medication Release of Liability form

   All forms must be in order and signed.

2. The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.

3. The school nurse will complete an Emergency Care Health Plan as appropriate.

4. The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.

5. The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.

6. Parents of students who will self-administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.

7. The parents will sign a form assuming full responsibility and releasing the school of liability.

8. The school’s registered nurse and principal will sign approving the request.

9. Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.

Health Services Manual: Medications R-4/15
REQUEST FOR APPROVAL FOR STUDENT TO CARRY PRESCRIBED MEDICATION

(This form is to be completed by the parent. The physician must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)
For online forms: [http://sbo.nn.k12.va.us/healthservices/medications.html](http://sbo.nn.k12.va.us/healthservices/medications.html)

Name of Student: ___________________________________   Birth date: _________________

Home Address: __________________________________________________________________________

Name of Parent(s):______________________________________________________________

Medication to be carried: ________________________________________________________

Reason student needs to carry: ____________________________________________________
______________________________________________________________________________

Additional information: __________________________________________________________
______________________________________________________________________________

I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it. I understand this request is for the current school year only.

_________________________________________  ________________________
Parent’s Signature      Date

Attached and completed: (All must be reviewed by RN)
___ Signed order from Medical Provider that student is trained and able to carry
___ Parent signature to request
___ Exception to Rule 3 & 26 (parent and student signed)
___ Medical Release of Liability

Notes:________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Approved for current school year:
_________________________________________  ________________________
School Nurse       Date

_________________________________________  ________________________
Principal       Date

R-4/15
Virginia Asthma Action Plan

**School Division:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Dates</th>
<th>/ / to / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider</td>
<td>Provider’s Phone #</td>
<td>Fax #</td>
<td>Last flu shot</td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td>Parent/Guardian Phone</td>
<td>Parent/Guardian Email:</td>
<td></td>
</tr>
<tr>
<td>Additional Emergency Contact</td>
<td>Contact Phone</td>
<td>Contact Email</td>
<td></td>
</tr>
</tbody>
</table>

**Asthma Severity:**

- [ ] Intermittent or Persistent: [ ] Mild [ ] Moderate [ ] Severe

**Asthma Triggers (Things that make your asthma worse):**

- [ ] Colds [ ] Smoke (tobacco, incense) [ ] Pollen [ ] Dust [ ] Animals: __________________________ [ ] Strong odors [ ] Mold/moisture [ ] Stress/Emotions
- [ ] Exercise [ ] Acid reflux [ ] Pests (rodents, cockroaches) [ ] Season (circle): Fall, Winter, Spring, Summer [ ] Other: __________________________

**Green Zone: Go! — Take CONTROL (PREVENTION) Medicines EVERY Day**

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

**Peak flow:** _____ to _____

(60% - 80% of Personal Best)

**Personal best peak flow:** __________

**Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.**

- [ ] No control medicines required.
- [ ] Dulera _______ [ ] Symbicort _______ [ ] Advair _______ , ___ puff(s) ___ times a day
- [ ] Alvesco _______ [ ] Asmanex _______ [ ] Azmacort _______ [ ] Flovent _______ [ ] Pulmicort _______ [ ] QVAR ______
- __________ MDI __________ times a day
- Or: __________ nebulizer treatment(s) __________ times a day
- [ ] Singular or __________________________, take _____ by mouth twice daily or bedtime

**For asthma with exercise,** **ADD:** [ ] Albuterol or __________, _____ puffs with spacer 15 minutes before exercise

**Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines**

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

**Peak flow:** _____ to _____

(60% - 80% of Personal Best)

- [ ] Albuterol or ______________________, _____ puffs with spacer every _____ hours as needed
- [ ] Albuterol or ______________________, one nebulizer treatment(s) every _____ hours as needed

**Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn’t work.**

**Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!**

You have **ANY** of these:

- Can’t talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

**Peak flow:** < ______

(60% of Personal Best)

- [ ] Albuterol or ______________________, _____ puffs with spacer every 15 minutes, for THREE treatments
- [ ] Albuterol or ______________________, one nebulizer treatment every 15 minutes, for THREE treatments

**Call your doctor while administering the treatments.**

**IF YOU CANNOT CONTACT YOUR DOCTOR:**

**Call 911 or go directly to the Emergency Department NOW!**

**REQUIRED SIGNATURES:**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery monitoring devices. I approve this Asthma Management Plan for my child.

- [ ] Parent/Guardian
- [ ] School Nurse/Designee
- [ ] Other

**CC:** [ ] Principal [ ] Cafeteria Mgr [ ] Bus Driver/Transportation [ ] Coach/PE [ ] Office Staff [ ] School Staff

**SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER**

**CHECK ALL THAT APPLY:**

- [ ] Student instructed in proper use of their asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.
- [ ] Student is to notify designated school health officials after using inhaler at school.
- [ ] Student needs supervision or assistance to use inhaler.
- [ ] Student should NOT carry inhaler while at school.

**MD/NP/PA SIGNATURE:** ___________________________ Date________

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/12

Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership

Blank copies of this form may be reproduced or downloaded from [www.virginiaasthma.org](http://www.virginiaasthma.org)
RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO RULE 3 (MEDICATION) AND RULE 26 (ALCOHOL AND OTHER DRUGS)

(Request to Carry Prescribed Medication on One’s Person)

I request my son/daughter ______________________________________ carry the following prescribed medication: __________________________________________________________.

I have read Rule 3 (Medication) and Rule 26 (Alcohol and Other Drugs) which state:

Rule 3.  Medication: A student must take all medication (prescribed or over-the-counter drugs) in the clinic.

Rule 26.  Alcohol and Other Drugs: Except as permitted under Rule 3 (Medications) a student shall not use, purchase, sell distribute, be under the influence of or possess any kind of alcoholic beverage or any kind of controlled substance as defined by state law. This prohibition includes, but is not limited to, anabolic steroids, substances that look like drugs, imitation controlled substances, and drug paraphernalia. For example:

E. Possession/Attempt – Possessing, or attempting to possess, any illegal or controlled substance or any action that contributes to the possession of any illegal or controlled substance.

H. Sale/Distribution/Purchase/Attempt – Distributing, selling or purchasing any illegal or controlled substance; attempting to sell, distribute, or purchase any illegal or controlled substance; or any action that contributes to the possession of any illegal or controlled substance.

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will be the same as Rule 26 E or H.

Level 7 Expulsion

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed______________________________________ (Parent)     Date: ___________________

Signed______________________________________ (Student)   Date: ___________________

R-4/15
MEDICATION RELEASE OF LIABILITY FORM

Student: ___________________________ School: ______________________   Grade: _______

Address: ______________________________________________________________________

Parent/Guardian: _____________________________________   Phone: #__________________

___________________________________________________   Phone: #_________________

(Home)                                                (Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of_________________________________________________________

I hereby request and authorize you to assist and/or give

_____________________________________________________________________________

(Dose and Medication)

to: ____________________________________________, as prescribed by

(Student’s Name)

_____________________________________________________________________________

(Doctor’s Name)

I release school personnel from liability should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

______________________________________________________________________________

______________________________________________________________________________

Parent/Guardian Signature                Date

R-4/15