DEER LAKES SCHOOL DISTRICT
INDIVIDUALIZED EMERGENCY/HEALTH CARE PLAN
ASTHMA

Name_____ Grade_____ Age_____ HR _____ School Year _____

SIGNS OF MILD ASTHMA ATTACK
Wheezing, coughing, chest tightness, shortness of breath during activity while at rest.

SIGNS OF A SEVERE ASTHMA ATTACK
Difficulty breathing, walking, talking, hunching over, lips or fingernails turn blue.
Chest and neck pulled or sucked in with each breath.

☆EMERGENCY ACTION PLAN:

1. If asthma attack is suspected, give _____
(Medication/dose/route)
and _____**IMMEDIATELY!**

2. **CALL 911** (Activate EMS) **IMMEDIATELY!**
3. **Notify Parent/Guardian**

INHALERS and NEBULIZERS
Inhalers, nebulizers and necessary medication are to be provided by parent and will be kept:

_____Nurse's office Date submitted: _____
_____Student will/may carry inhaler with him/her at all times
-Specific Designated area:_____
-Student must agree not to remove inhaler **for any reason** (other than usage)
_____Other: _____

FIELD TRIPS
Necessary arrangements needed on field trips:

Please address any other guidelines or special precautions that you feel is important to child's safety and care during the school day. Please be very specific:

SELF ADMINISTRATION OF INHALER/CONTRACT BETWEEN STUDENT/PARENT/ DOCTOR & NURSE

Does child self administer inhaler Yes * No

*If yes, student must:
-Understand circumstances/symptoms associated with their need for inhaler
-Know proper technique of self administration of inhaler
-Agree **NEVER** to share inhaler with another student
-Agree that after 2 puffs, if there is no improvement, he/she will go to the school nurse immediately.
-Student agrees not to exceed the allowed dosage.

_____ _____
Physician's Signature Date

As the parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer, if the medication policy is violated.

I give my permission for my child_____ to carry the inhaler(s) described above. I understand that she/he must follow the rules listed above. I agree to notify the school nurse of any medication changes or changes in my child's condition. I give the school nurse permission to contact the physician, if she has any questions or problems regarding my child's condition.

My signature indicates that I have completed the above information and agree with the recommended actions. I also authorize the release of this Individualized Health Care Plan to the employees of Deer lakes School District.

_____ _____

Parent/Guardian Signature Date

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

_____ _____

Student Date

I agree that the above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

_____ _____

Certified School Nurse Date

5/03

DEER LAKES SCHOOL DISTRICT
Medication Permission Form

Dear Parent and Physician:

Deer Lakes School District strongly recommends that student medications be administered at home, before or after school. If, under exceptional circumstances, it is absolutely necessary that the medication be giving during school hours, the following guidelines must apply:

1. **For the safety of your child, students are not permitted to transport or carry with them any medication (over the counter or prescription) at any time. Exceptions to this are outlined below.**
2. **No medications will be given back to the student to transport home.**
3. **Prescription medication must be in the original prescription labeled container (you can request a duplicate container from the pharmacist) accompanied by this completed form or a physician written order and a detailed note with parent/guardian signature.**
4. **Non-Prescription medication must be in the original container with student's name and accompanied by this form or a detailed note, indicating name of medication, dose, and time to give from parent/guardian. The nurse will request a physician's order to administer an over the counter medication.**
5. **Students who are authorized by a doctor to carry and/or self-administer a medication violate the Alcohol and Other Drugs policy IF he/she permits another student to take or ingest the medication.**
6. **Any medication not picked up by the last day of school will be disposed of in a non-recoverable manner.**

Student's Name_____ _____

Last **First** **Grade**

I have read the above information and request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself (as outlined below) also by me and my physician. We agree to hold the school, its offices, agents and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.

▶▶

PRESCRIPTION/OVER THE COUNTER MEDICATIONS **The PHYSICIAN must complete the following:**

Name of Medicine_____Form_____Dose_____
Time to be administered _____
Reason for Medication _____
Duration of time medication is required in school: _____
If medicine is to be given "WHEN NEEDED" describe indications: _____
How soon can it be repeated? _____
List significant side effects: _____
Length of time this treatment is recommended_____

PERMISSION TO CARRY AND/OR SELF MEDICATE

Is child authorized to medicate herself/himself? (Ex. Epi Pen or Inhaler) Yes____ No_____

Student may carry inhaler, epipen (or other) in school or on Field Trips? Yes____ No_____

Any other necessary information: _____

Physicians Signature: _X_____ Date: _____

PARENT SIGNATURE: X_____DATE:_____

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