Moving Forward

Bullitt County Public Schools

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Parent ☐
Physician ☐

ASTHMA PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2018-2019 school year. Attached is an asthma school action plan and medication permission form that will need to be completed **in full** with physician signature prior to bringing the medication to school.

IMPORTANT NOTES TO COMPLETING THE ASTHMA ACTION FORM:

IF your child will be *carrying and self-administering* the inhaler then MD **and** parent/guardian will need to *complete full asthma action page*.
IF inhaler will be *kept in office* and NOT self-administered, then parent/guardian *complete ONLY top portion* of asthma action form.

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

- **Asthma Action Plan completed and on file at school; MD** *must complete bottom portion of form.*
- **Medication Permission Form is complete and on file at school;**
- **Primary Care Provider has instructed student in self-administration of the student's prescribed medication to treat asthma.**
- **Updated form(s) provided each school year**

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.

As our policy 09.2241 states, " All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted." Inhalers must be brought in the original box with the prescription label on the front. Children's names written on Ziploc baggies will not be accepted. ***If the child has orders from the physician to carry the inhaler on their person, then the prescription box must be left in the office. However, please write your child's name on the inhaler***.

Please remember that the schools are not to administer any medication and your child is not to carry any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public Schools

BULLITT COUNTY PUBLIC SCHOOLS HEALTH SERVICES

ASTHMA ACTION PLAN-*must be submitted with medication form*

Student: _____ DOB: _____

School/Grade: _____Current Age: _____ School Year: _____
Medical Condition-Asthma: _____ Controlled _____ Chronic _____ Acute when ill _____ Seasonal
Date of last asthma episode: _____
Parent/Guardian Name: _____ Telephone: _____

ASTHMA TRIGGERS, SYMPTOMS AND INTERVENTIONS

Triggers (Check all that apply to this child)

☐ Exercise ☐ Animals ☐ Fumes ☐ Change in Temperature ☐ Foods (Specify):_____
☐ Strong Odors ☐ Pollen ☐ Molds ☐ Respiratory Infection ☐ Other (Specify):_____
☐ Chalk Dust ☐ Carpet ☐ Latex ☐ Trees/Grass/Shrubbery

Signs and Symptoms student will likely exhibit (Check all that apply)

☐ Coughing ☐ Wheezing ☐ Labored/Difficulty Breathing ☐ Other (Specify): _____

Please provide helpful **interventions** or measures to be taken: _____
_____

MEDICATION ADMINISTRATION –REQUIRES PRESCRIPTION LABEL & MEDICATION PERMISSION FORM (09.2241 AP.21)
Medication form must addresses condition to use; location of inhaler; frequency of puffs ordered; & if to be administered prior to exercise or going outdoors

All Current Medications**:**
1._____ 2. _____ 3._____ 4. _____

_____ _____
Signature of Parent/Guardian ***Date***

PHYSICIAN AUTHORIZATION for SELF-ADMINISTRATION BY STUDENT
Physician and Parent/Guardian Signature required per KRS 158.834

_____ is to be administered ROUTINELY under what conditions: _____
Medication/Inhaler
_____ is to be administered under what SPECIAL conditions: _____
Medication/Inhaler
_____ (*MD INITIALS*) This student has been instructed by PHYSICIAN regarding the care, storage and use of this prescribed medication and has the ability to determine appropriate administration of the medication. The medication must be carried on the student's person and will be labeled with the student's name.
_____ (*MD INITIALS*) This student has been instructed by PHYSICIAN that if symptoms are not relieved by medication administration, STUDENT must notify a school staff member or other supervising adult immediately.

_____ _____ _____
Signature of MD, DO, ARNP or PA Telephone Date

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION BY STUDENT

Signing this form shall release Bullitt Co. Board of Education and its employees from liability for any injuries resulting from your student carrying, maintaining, and self-medicating. Parent/guardian agrees to hold harmless BCPS employees from any claim resulting from student's self-administration of medication to treat Asthma per state law KRS 158.834. Permission for self-administration of medication shall be effective for the school year in which it is granted by Physician and Parent and shall be renewed each following school year.
Parent/Guardian of _____ AGREES that it is the responsibility of the parent/guardian to require the student to be in possession of the above prescribed medication during the school day, extracurricular activities and during field trips. Replacement of expired medication is the responsibility of the parent/guardian.

_____ _____ _____
Signature of Parent/Guardian Home Phone and/or Cell Date

EMERGENCY PLAN OF ACTION for STUDENTS WITH ASTHMA

1. STOP all activity; allow child to rest**.** Assume position of comfort. Offer sips of warm fluids **DO NOT SEND TO OFFICE OR BE LEFT ALONE**

2. STAY with student and monitor symptoms:

a. If symptoms decrease after taking medication, student may return to class.

b. If symptoms remain the same 15 minutes after taking medication, parent will be contacted for direction

c. If symptoms increase in severity **9-1-1** will be called and resuscitation begun if necessary. Contact parent.

i. Symptoms may include: nostrils open and flaring, can't walk or talk due to shortness of breath, lips or fingernails blue.

3. **If no medication is ordered/available for student, the parent will be called and/or 9-1-1 depending on the severity**

Permission Forms for Medication

Student's Name: _____ Grade: _____ Age:_____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of medication:_____ **Reason for medication:**_____ **Instructions: Time:**_____ **Dose:**_____ **Start Date:**_____/_____/_____ **Stop Date:**_____/_____/_____	**Name of medication:**_____ **Reason for medication:**_____ **Instructions: Time:**_____ **Dose:**_____ **Start Date:**_____/_____/_____**Stop Date:**_____/_____/_____
Signs & symptoms of emergency administration: _____ Restriction and/or important side effects: No restrictions Yes. Please describe:_____ Other *Student must carry this medication on his/her person and self-administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Signs & symptoms of emergency administration: _____ Restriction and/or important side effects: No restrictions Yes. Please describe:_____ Other *Student must carry this medication on his/her person and self- administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) Student requires medication to be administered (School personnel will hold medication and administer)

_____***(MD INITIALS)** The above named student has been instructed on the care, storage, dosage, and use of the above medication(s) and has sufficient knowledge and ability to self-administer the medication(s) in the school setting and while on field trips.

_____
*Physician/Health Care Provider Signature/Date

Physician Practice name:_____

Address:_____

Phone: (___)_____ Fax: (___)_____

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS.

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion.

Administrator/designee _____ Date _____

Review/Revised: 6/19/2017

Consent Form for Mutual Exchange of Information

Student's Name: _____ Date: _____

Date of Birth: _____ Parent/Guardian: _____

Address: _____

I the parent/guardian of the above named student hereby authorize the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Name: _____ Phone #: _____
(Physician's name)

Address: _____

The information will be used or disclosed upon request for the following purposes:

- ☐ Developing a medical plan for the student at school
- ☐ Assessing the need for a medical transfer
- ☐ Assessing the need for the student to access the Home Hospital Program
- ☐ Addressing medical needs related to treatment for the following condition or injury _____ on or about _____
- ☐ Reviewing medical records covering the period of time _____ to _____
- ☐ Addressing issues related to the student missing school/excessive absences
- ☐ Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: _____

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

_____ _____
Signature Date

Public Law 93-380 (Federal Family Educational Rights and Privacy Act of 1974) specifically states that school records may be released to third parties provided:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. The reason for the release is stated.
3. The identity of the third party is specified.
4. The parents receive a copy of the record, if desired.
5. The records to be released are specified.

Review/Revised: 7/19/11