FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

# SCHOOL ASTHMA ACTION PLAN

**Student Name:** _____ **DOB:** _____ **Date form completed:** _____
**School:** _____ **Teacher:** _____

☐ **For exercise**: _____ Inhaler _____ puffs 15-30 minutes before exercise

Immediate action is required when the above-named student exhibits any of the following signs of an asthma attack:
Repetitive Cough Shortness of Breath Chest tightness Wheezing/Retractions Inability to speak in sentences

☐ **Steps to take during an asthma flare:**

1. Give emergency asthma medications as listed below:

| | Quick Relief Medication | Dose | Frequency |
|---|---|---|---|
| ☐ | Albuterol Inhaler | 2-4 puffs with spacer | Every 2-4 hours prn for cough |
| ☐ | Albuterol Neb | | |
| ☐ | Xopenex Neb | | |
| ☐ | Other Medications | | |

Reassess in 10-15 minutes and reclassify the child according to the following parameters:

| | Cough | Respiratory Rate | Accessory muscle use or retractions | Work of breathing or shortness of breath |
|---|---|---|---|---|
| **Normal** | None to occasional | **Normal Rate**<br>2-4 y/o <32<br>5-6 y/o <28<br>7-14 y/o <25<br>>15 y/o <22 | None | • Normal<br>• Easily speaks in sentences |
| **Asthma symptoms continue** | Very frequent to constant | > normal for age | Present | Speaks in short sentences, or only in words |

2. If the child is:
   - Normal – the child may return to the classroom
   - Continues with asthma symptoms – continue with the medication listed in number 1 above every 15-30 minutes until EMS arrives
3. Activate EMS (call 911) IF the student has ANY of the following symptoms:
   - Lips or fingernails are blue or gray
   - The student is too short of breath to walk, talk, or eat normally
   - The student gets no relief within 10-15 minutes of quick relief medicines OR the child has any of the following signs:
     - Persistent chest and neck pulling in with breathing
     - Child is hunching over
     - Child is struggling to breathe
     - Child's asthma symptoms continue as outlined in the table above.

☐ I certify that this child has been trained in the use of the listed medication, and is judged by me to be:
_____capable of carrying and self-administering the listed medication(s),
_____NOT capable of carrying and self-administering the listed medication(s).

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

The child should notify the school staff if one dose of the asthma medication fails to relieve asthma symptoms for at least 3 hours.

| | |
|---|---|
| **Healthcare Provider Name:** | **Healthcare Provider Signature:** |
| **Healthcare Provider Address:** | **Healthcare Provider Phone Number:** |
| **Parent Name and Address** | **Parent Signature** **Date** |

Reviewed by School Nurse:_____ Date:_____

*Refer to 504 coordinator if appropriate

Updated 7/11

FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

# REQUEST FOR ADMINISTRATION OF MEDICATION

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.
Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

Medications must be in the original container.

Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.

It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.

All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Forsyth County care plan.

Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).

A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.

**MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

**NAME OF STUDENT** _____ **BIRTHDATE** _____
**SCHOOL** _____ **GRADE** _____ **TEACHER** _____
**MEDICATION** _____ **DATE OF PRESCRIPTION** _____
**PHYSICIAN'S NAME** _____ **PHYSICIAN'S PHONE** _____
**DOSAGE & TIME OF ADMINISTRATION** _____
**ALLERGIES** _____ **STOP MEDICATION ON** _____

## STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

**SIGNATURE OF PARENT/GUARDIAN** _____ **DATE** _____
**HOME PHONE** _____ **WORK PHONE** _____ **CELL** _____

***To be completed by Physician for long-term medications (more than two weeks):***
***"Physician" as defined in Article 2 of the Medical Practice Act of Georgia***

**CONDITION/ILLNESS REQUIRING MEDICATION** _____
**POSSIBLE SIDE EFFECTS OF MEDICATION** _____
**OTHER MEDICATION STUDENT IS TAKING** _____

**PHYSICIAN'S SIGNATURE** _____ **DATE** _____

**Parent/Guardian Picked Up Medication Date** _____

**Parent Signature** _____ **Nurse** _____ **Date** _____

# ADMINISTRATION OF MEDICATION INFORMATION

*(This information is on the reverse side of the Request for Administration of Medication Form)*

The administration of medication to students during the school day presents an increased concern and awareness of the need to have written procedures.

Medication may be dispensed to students with the assistance of school personnel whenever physicians find it necessary to prescribe medication to be taken during school hours. School personnel will cooperate with parents in this regard by providing a place for the medication to be stored; however, *the major responsibility for a child taking medication at school rests entirely with the child's parents.*

A nurse is not always available to assist in the administration of the medication. The student may be assisted by an adult designated by the principal.

Prescription and non-prescription medication will be given to students by school personnel only when the following guidelines are observed:

***All medication MUST be in its original container and MUST be brought to school by the parent or guardian.** Medications brought in baggies or other unmarked containers will not be given. Prescription medication must be in the pharmacy container labeled with the child's name, date, name of medication, name of the prescribing physician, time(s) the medication is to be given and name of the pharmacy filling the prescription. We request that you ask the pharmacist to give you two labeled prescription bottles so that you have one bottle at home and one at school.

*A "Request for Administration of Medication" form (see back) must be completed by the parent/guardian (and physician if the medication needs to be given for longer than two weeks - such as (Ritalin) and sent to school along with the medication.

***Do not send medication to school which needs to be given daily or two/three times a day unless the physician specifically states a time during the school day which it is to be given.** An antibiotic which is to be given three times daily can be given before the child leaves for school, when he/she gets home, and at bedtime.

*School personnel cannot give medication that contains aspirin to students under 18 years old due to the correlation with Reyes Syndrome. Examples are Pepto Bismol, Excedrin Migraine, Goody's Powder.

The safety and well-being of your child are our concern. With your understanding and cooperation, we can eliminate much of the unnecessary medications that are brought to school and ensure that our students who do need to take medication at school will receive it appropriately. If you have any questions regarding medications, please call your child's school or you may call the school nurse.

FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

# AUTHORIZATION FOR STUDENTS TO CARRY A PRESCRIPTION INHALER, EPINEPHRINE AUTO INJECTOR, INSULIN, AND DIABETIC SUPPLIES, OR OTHER APPROVED MEDICATION

_____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or_____ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

***It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.***

**Name of Medication:** _____

_____ _____
*Physician's Name* *Date*

_____ _____
*Physician's Address* *Phone*

_____ _____
*Physician's Signature* *Date*

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the School Nurse each time I take my medication.

_____ _____
*Student's Signature* *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above-named student administers his/her own medication.

_____ _____
*Parent/Guardian Signature* *Date*