School Year ____-____

City of St. Charles R-6 School District

400 North Sixth St., St. Charles, MO 63301

St. Charles High School
Clinic Phone: 636-443-4103 Fax: 636-443-4101

Information for Inhaler Administration at School

There are two choices for students using inhalers at school:

1. Keep the inhaler in the clinic and use it as needed, or
2. Carry and self-administer the inhaler

Forms needed for Choice 1: Keep the inhaler in the clinic and use it as needed

1. **STUDENT ASTHMA ACTION FORM** is two pages. The parent/guardian must complete the first section, plus *sign and date* the form where indicated.
2. The prescribing physician must complete the remainder of the form and *sign and date* at the bottom of page 3.
3. **PRESCRIPTION MEDICATION FORM** (page 4) **must** be *completed and signed* by both the **prescribing physician** and the **parent/guardian *if*** the physician does *not* choose to complete the ASTHMA ACTION FORM.

Forms needed for Choice 2: Carry and self-administer the inhaler at school

1. **STUDENT ASTHMA ACTION FORM** is two pages. The parent/guardian must complete the first section, plus *sign and date* the form where indicated.
2. The prescribing physician must complete the remainder of the form and *sign and date* at the bottom of page 3.
3. **PERMISSION FOR STUDENT TO SELF-ADMINISTER MEDICATION BY METERED DOSE INHALER FORM** (page 5) **must** be completed by the parent/guardian to allow the student to *carry and self-administer* their prescribed inhaler.

All forms will be submitted to the school nurse along with the actual inhaler. Notify the nurse if the student is playing sports so a copy can be given to the athletic trainer.

FORMS MUST BE RENEWED YEARLY

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STUDENT ASTHMA ACTION FORM

Parent/Guardian: Please complete this section

Student's Name: _____ Date of Birth: _____ Grade: ____

Parent/Guardian:

Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Parent/Guardian: Phone (C) _____

Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Phone (C) _____

Emergency Phone Contact #1 _____ _____ _____

Name Relationship Phone

Emergency Phone Contact #2 _____ _____ _____

Name Relationship Phone

Student's Asthma Physician: _____ _____

Phone

Student's Primary Physician: _____ _____

Phone

_____ _____

Parent/Guardian Signature **Date**

Physician: Please complete remainder of form

DAILY ASTHMA MANAGEMENT PLAN

*** Identify the things that start an asthma episode (Check all that applies to the student).**

__ Exercise __ Foods: _____ __ Pollens

__ Respiratory Infections __ Animals __ Molds

__ Change in temperature __ Chalk dust __ Other:_____

__ Strong odors or fumes __ Carpets in the room _____

Comment's: _____

*** Control of School Environment**

List any environmental control measures, pre-medications, dietary restrictions, and/or activity restrictions for recess or physical education class that the student needs to do to prevent an asthma episode.

_____

_____

_____

*** Peak Flow Monitoring**

Personal Best Peak Flow Number: _____

Monitoring Times: (1) _____ (2) _____ (3) _____

Physician: Please complete remainder of form for student: _____ **DOB:** _____

*** Daily Medication Plan**

NAME OF MEDICINE	AMOUNT	WHEN TO USE
1.		
2.		
3.		
4.		

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms as _____
_____ or has a peak flow reading of _____.

*** Steps to take during an asthma episode:**

1. Give medication as listed below
2. Have student return to classroom if _____
   _____
3. Contact parent if _____
4. **Seek emergency medical care if the student has any of the following:**

- ❑ If no improvement 15-20 minutes after initial treatment with medication and relative cannot be reached.
- ❑ Peak flow of _____
- ❑ Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breath
- ❑ Trouble walking or talking
- ❑ Stops playing and can't start activity again
- ❑ Lips or fingernails are gray or blue

IF THIS HAPPENS GET EMERGENCY HELP NOW!

*** Emergency Asthma Medications**

NAME OF MEDICINE	AMOUNT	WHEN TO USE
1.		
2.		
3.		
4.		

COMMENTS/SPECIAL INSTRUCTIONS (PLEASE INCLUDE RECESS &/or PHYSICAL EDUCATION RESTRICTIONS)
_____
_____
_____

FOR INHALED MEDICATIONS

__ **If this line is checked, the patient has been instructed on use of this medication & is capable of self-administration. Side effects & dangers of improper use have been reviewed.**

__ It is my professional opinion that _____ should not carry his/her inhaled medications by him/herself.

_____ _____
Physician Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

Rev. April, 2016

City of St. Charles R-6 School District
400 North Sixth Street, St. Charles, MO 63301

PRESCRIPTION MEDICATION FORM GRADES 5-12

Building: St. Charles High School Phone: 636-443-4103

Contact: School Nurse Fax: 636-443-4101

ADMINISTRATIVE PROCEDURES FOR GIVING PRESCRIPTION MEDICINE AT SCHOOL

The giving of medicines by the nurse, principal or designee shall be restricted to necessary medicines that cannot be given on an alternative schedule. Prescription medicines will be in the original pharmacy/prescriber labeled container showing: **a)** student's name **b)** name of medicine **c)** dosage and administration schedule **d)** prescriber's name and **e)** date purchased. The student's authorized prescriber is a medical professional with prescriptive authority such as a physician, dentist, orthodontist, etc. **The District will not administer the first dose of an initial prescription**.

Procedure for the administration of prescription medicine:

1. The following form must be completed, signed and dated by the prescriber and parent/guardian.
2. Medication will be provided in the original container appropriately labeled. Note: ask the pharmacist for an extra labeled container so you can have one for school and one for home.
3. Prescription pills brought to school by a student must have a signed and dated note from a parent/guardian stating the number of pills sent to school. The pills must be taken to the clinic by the beginning of classes that day.
4. Medicine will be permitted in the school or administered in the school ONLY in accordance with this procedure.
5. Medicine name, dosage and instructions must be in English.

Student's Name: _____Date of Birth: _____ Grade: ____ **School Year** _____-____

TO BE COMPLETED BY PHYSICIAN:

Medicine, dose and route: _____

Time/interval to be given: _____ Start date:_____

Known Drug Allergies: _____ Discontinue date: _____

Possible Side Effects to be observed: _____

Diagnosis/Indication for use:_____

(Signature of parent/guardian or independent student below gives permission to release this information.)

I request that the St. Charles School District administer this medicine to this student.

_____ _____ _____

Printed Name of Physician | Signature of Physician | Date

_____ _____ _____

Address of Physician | Phone Number of Physician | Fax Number of Physician

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that the St. Charles School District's designated personnel administer the above medicine to my child.
I also give permission for the authorized prescriber to release the required information for safe administration of this medicine at school. I understand that the nurse has the right to question any medication order he/she deems potentially inappropriate, and to verify the validity of any medication order. I also understand that it is the right of the nurse to refuse to give any medicine that he/she feels does not meet the criteria established by Nursing Procedure and the St. Charles School District.
I will inform school personnel of any change in the student's health or change in medication and understand that an additional written request for any change of this medicine must come from the authorized prescriber.

_____ _____ _____ _____

Parent/Guardian Signature | Date | Home Phone | Work Phone

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PERMISSION FOR STUDENT TO SELF-ADMINISTER MEDICATION BY METERED-DOSE INHALER

I hereby certify the following:

1. I, _____, am the parent or legal guardian of _____ ("Student"), a student in the St. Charles School District ("District"), and am legally authorized to make educational and health care decisions for the Student.
2. I have provided the District with a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having asthma or other potentially life-threatening respiratory illness ("Condition").
3. I have provided the District with written certification from the Student's physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self-administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.
4. I understand the District and its employees or agents my disclose information provided in accordance the foregoing paragraphs to administrators, school nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer medication by means of a metered-dose inhaler, and shall incur no liability for the disclosure of such information.
5. I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student.
6. I understand that this permission for is effective for the school year for which it is granted, and that a new Permission Form and supporting documentation as described above, must be submitted for each school year.

_____ _____

Date Date Received by Nurse

_____ _____

Signature of Parent/Guardian Signature of School Nurse

FORMS MUST BE RENEWED YEARLY