



Bullitt County Public Schools

Parent	<input type="checkbox"/>
Physician	<input type="checkbox"/>

1040 Highway 44 East
Shepherdsville, Kentucky 40165

Phone: 502-869-8000
Fax: 502-543-3608
www.bullittschools.org

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 2020-2021 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 School

Year _____

BULLITT COUNTY PUBLIC SCHOOLS HEALTH SERVICES

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

Student: _____ **DOB:** ___/___/___ **Age:** _____

School: _____ **Grade:** _____ **Date of last asthma episode:** ___/___/___

Medical Condition-Asthma: _____ **Controlled** _____ **Chronic** _____ **Acute when ill** _____ **Seasonal**

ASTHMA TRIGGERS, SYMPTOMS AND INTERVENTIONS

Triggers (Check all that apply to this child)

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Carpet | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Respiratory Infection | (Specify): _____ |
| <input type="checkbox"/> Fumes | <input type="checkbox"/> Trees/Grass/Shrubbery | _____ |
| <input type="checkbox"/> Molds | <input type="checkbox"/> Strong Odors | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> Chalk Dust | <input type="checkbox"/> Change in Temperature | |

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 address condition to use; location of inhaler; frequency of puffs ordered; & if to be administered prior to exercise or going outdoors

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.
2. **DO NOT SEND TO OFFICE OR BE LEFT ALONE**
3. Follow the medication administration form instructions filled out by both the physician and parent or guardian. Please be aware of medication location and if the student is self-medicating. If the student is self-medicating please have a plan as to where the student will keep that medication.
4. **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.

(Symptoms may include: nostrils open and flaring, can't walk or talk due to shortness of breath, lips or fingernails blue.)
5. **If no medication is ordered/available for student, the parent will be called and/or 9-1-1 depending on the severity.**

I/WE give permission for _____ to receive the prescribed medications listed on the "Medication Permission Form" for any medications given at school according to standard school policy and expressly hold harmless, and waive any liability on behalf of,

Student's Name

the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the 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. I/We acknowledge that the school district shall incur no liability and I/We shall indemnify and hold harmless the school district and its employees against any claims relating to the self-administration or administration by school personnel of medications used to treat asthma.

XParent/Guardian Signature _____ Date _____ Phone _____

Physician Signature: _____ Physician Printed Name: _____

Permission Forms for Medication
PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

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

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

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.

<p>Name of Medication: _____</p> <p>Reason: _____ Stop date: ____/____/____ or End of School Year</p> <p>Time to be given: _____ Dose _____ MG/ML/PUFFS/UNITS (please circle one)</p> <p>Signs and symptoms of emergency administration: _____</p> <p>Restriction and/or important side effects: _____</p> <p>* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) <input type="checkbox"/> Yes (*MD to initial below) <input type="checkbox"/> No</p> <p><u>SPECIFIC TO FIELD TRIPS ONLY:</u> (Please check 1 box) <input type="checkbox"/> Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time)</p> <p><input type="checkbox"/> * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) (*MD to initial below)</p> <p><input type="checkbox"/> Student requires medication to be administered (School personnel will hold medication and administer)</p>	<p>Name of Medication: _____</p> <p>Reason: _____ Stop date: ____/____/____ or End of School Year</p> <p>Time to be given: _____ Dose _____ MG/ML/PUFFS/UNITS (please circle one)</p> <p>Signs and symptoms of emergency administration: _____</p> <p>Restriction and/or important side effects: _____</p> <p>* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) <input type="checkbox"/> Yes (*MD to initial below) <input type="checkbox"/> No</p> <p><u>SPECIFIC TO FIELD TRIPS ONLY:</u> (Please check 1 box) <input type="checkbox"/> Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time)</p> <p><input type="checkbox"/> * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) (*MD to initial below)</p> <p><input type="checkbox"/> Student requires medication to be administered (School personnel will hold medication and administer)</p>
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PROVIDER SIGNATURE FOR ALL MEDICATIONS

Physician/Health Care Provider Signature _____ Date ____/____/____	Physician Practice name: _____ Address: _____ Phone: (____) _____ Fax: (____) _____
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***FOR SELF CARRYING/ SELF ADMINISTRATION ONLY**

_____(MD INITIALS) The above-named student has been instructed on the care, storage, dosage, and use (up to/and including getting help of trained personnel if student feels they are unable to administer the medication safely/effectively in an emergency situation) of the above medication(s) and has sufficient knowledge and ability to self-carry / self-administer the medication(s) in the school setting and while on field trips.

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 ____/____/____

Consent Form for Mutual Exchange of Information

Student's Name: _____ Date: _____

Date of Birth: _____ Social Security Number: XXX-XX-_____

Parent/Guardian: _____

Address: _____

I, the parent/guardian of the above-named student, hereby authorizes 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.

Physician, Individual, or Organization Name: _____

Address: _____ Phone #: _____

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 issues related to the student missing school/excessive absences.

Please allow consultation and/or forward documents to Bullitt County Public Schools:

- Addressing medical needs related to treatment for the following condition or injury
_____ on or about _____.
- Including medical records covering the period of time _____ to _____.
- Reviewing or requesting any and all progress notes, care plan notes, and/or discharge notes to assess student needs, covering the period of time _____ to _____.
- 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 if my healthcare provider is asking to use/disclose my information, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under 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	Relationship	Date
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34 CFR SEC 99.30 (Federal Family Educational Rights and Privacy Act of 1974) allows the release of certain records to third parties when:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. Written consent must: a. Specify the records to disclose. b. Purpose of disclosure. c. Identify whom disclosure made.
3. When disclosure is made: a. Parent or eligible student to receive a copy of records, if desired. b. Student to be provided a copy of the records disclosed, if parent requests.
4. Signed and dated written consent may include signature in electronic form if person is identified, authenticated and person's approval indicated.