Fulton Science Academy 2019-2020

Asthma Action Plan & School Medication Authorization

Name:	DOB: Grade:	Date:
Important! Things that make your asthma worse (Triggers): □ smoke □ pets □mold □dust-mites □pollen/trees □colds/viruses □exercise □seasons: other:		

Severity Classification: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

GO ZONE – You're Doing Well! USE THESE MEDICINES EVERYDAY TO PREVENT SYMPTOMS

If you have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

CONTROLLER MEDICINE (Dose/Route)	HOW MUCH	HOW OFTEN/WHEN
1. _____	_____ Puffs Inhaled □ **with spacer**	**AM/PM**
2. _____	_____	**AM/PM**
3. _____	_____	**AM/PM**
4. Albuterol MDI 90	_____ Puffs Inhaled **with spacer**	
➢ **Please order a VHC Spacer to use with any MDIs**	☐ **Every 4 hours as needed before exercise**	

CAUTION ZONE – Slow Down! CONTINUE WITH GO ZONE MEDICINE and ADD:

If you have *any* of these:

- First signs of a cold
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

RESCUE MEDICINE	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90	_____ Puffs Inhaled **with spacer**	Every _____ hours
OR	☐May Repeat x 1 in 20 minutes ***if needed***	
2. Nebulized Albuterol 2.5mg	_____ Vial inhaled	Every _____ hours
	☐ May repeat x 1 in 20 minutes ***if needed***	
3. _____	_____	_____

➢ **If getting worse follow directions in DANGER ZONE and Call your Health Care Provider**

➢ **If not improved in 2 days or any asthma questions/concerns - Call your Health Care Provider**

School Nurse: Call parent or provider if using PRN medication more than 2 days/week for asthma symptoms or for control concerns

DANGER ZONE – Get Help! TAKE THESE MEDICINES AND CALL YOUR PROVIDER NOW

If your Asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
1. Albuterol MDI 90	_____ Puffs Inhaled **with spacer**	**NOW!**
OR		☐ Repeat x 1 in 20 minutes ***if needed***
2 .Nebulized Albuterol 2.5mg	_____ 1 vial inhaled	**NOW!**
		☐ Repeat x 1 in 20 minutes ***if needed***

➢ **Call your Health Care Provider now! If they are not available, go directly to the emergency room or call 911 and bring this form with you. Make an appointment after all E.R. visits.**

HEALTH CARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR Albuterol as stated in above plan, and in accordance with GA State Law and Regulations 10-212a * Not to exceed **6 puffs** within regular school hrs (6hrs), without notifying provider **Office Stamp**

Side effects: ☐Not expected, or _____ Medication Allergies: ☐ NKDA, or _____

Self–Administration: ☐This student **is** capable to safely and properly self-administer this medication **OR**
☐This student **is not** approved to self-administer this medication

Signature: Date: Duration: One school year /365 days

Parent/Guardian Consent: REQUIRED

☐ I authorize the student to **possess** and **self-administer** medication **OR** ☐ I authorize this medication to be **administered by school personnel**

➢ I authorize exchange of information between the prescribing health care provider and school nurse to ensure the safe administration of this medication plan

Signature: Date: *** Bring asthma meds and spacer to all visits**

Nurse Signature Date: Acknowledges review of Medication Plan

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20_____ - 20_____

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

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 Fulton Science Academy 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 Fulton Science Academy 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**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION **Inhaler** _____ **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

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

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

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 ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20_____ - 20_____

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

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 Fulton Science Academy 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 Fulton Science Academy 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**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION **Nebulizer** **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

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

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

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 ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____

AUTHERIZATION FOR STUDENTS TO CARRY A PRESCRIPTION LABELED INHALER, EPINEPHARINE AUTO INJECTOR, INSULIN, GLUCAGON, DIABETIC SUPPLIES, EMERGENCY SEIZURE MEDICATION, OR OTHER APPROVED MEDICATION.

20_____ - 20_____

EACH MEDICATION WILL REQUIRE A PRESCRIPTION LABEL ATTACHED TO THE ACTUAL 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. **ASK your pharmacist to make separate prescription labels for each device, for school, for home, and for the one you are carrying.

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 Fulton Science Academy and its employees of any legal responsibility when the above-named student administers his/her own medication.

_____ _____

Parent/Guardian Signature *Date*