MEDICATION ORDER TO CARRY ASTHMA INHALER

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY PRESCRIBED MEDICATION

For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

These requests are exceptions to School Board policy JLCD and must be approved.

1. ***Parents will submit the following forms:***
   - ***a.*** ***Request for Approval for Students to Carry Prescribed Medication*** *(completed by parent)*
   - ***b.*** ***Completed Asthma Action Plan and Authorization for Medication form*** *(completed by medical provider)*
   - ***c.*** ***Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook (Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)***
   - ***d.*** ***Medication Release of Liability form***

   All forms must be in order and signed.

2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

3. *The school nurse will complete an Emergency Care Health Plan as appropriate.*

4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*

5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*

6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

8. *The school's registered nurse and principal will sign approving the request.*

9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

REQUEST FOR APPROVAL FOR STUDENT TO CARRY PRESCRIBED MEDICATION

(<u>This form is to be completed by the parent</u>. The medical provider must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)
For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

Name of Student: _____ Birth date: _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

_____

Additional information: _____

I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. ***A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it.*** *I understand this request is for the current school year only.*

_____ _____
Parent's Signature *Date*

Attached and completed: (All must be reviewed by RN)
___ *Signed order from Medical Provider that student is trained and able to carry*
___ *Parent signature to request*
___ *Exception to Categories BSC and BESO (parent and student signed)*
___ *Medical Release of Liability*

Notes:_____
_____
_____

Approved for current school year:
_____*, RN* _____
School Nurse *Date*

_____ _____
Principal *Date*

R-12/21

NEWPORT NEWS PUBLIC SCHOOLS

Health Services

12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)

(Request to Carry Prescribed Medication on One's Person)

I request my son/daughter _____carry the following prescribed medication: _____.

I have read Category BSC and Category BESO which state:

> ***Category BSC****: Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*
>
> ***Category BESO****: Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from to school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed_____ (Parent) Date: _____

Signed_____ (Student) Date: _____

R-12/21

NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

MEDICATION RELEASE OF LIABILITY FORM

Student: _____ School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone: #_____
(Home)

_____ Phone: #_____
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of_____

I hereby request and authorize you to assist and/or give

_____
(Dose and Medication)

to: _____, as prescribed by
(Student's Name)

_____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

_____

_____

_____ _____
Parent/Guardian Signature Date

R-12/21

Virginia Asthma Action Plan

Print & Save | Clear Form

School Division:

Name			Date of Birth
Health Care Provider	Provider's Phone #	Fax #	Last flu shot
Parent/Guardian	Parent/Guardian Phone		Parent/Guardian Email:
Additional Emergency Contact	Contact Phone		Contact Email

Asthma Triggers (Things that make your asthma worse)

☐ Colds	☐ Dust	☐ Animals:	☐ Strong odors	Season
☐ Smoke (tobacco, incense)	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/moisture	☐ Fall ☐ Spring
☐ Pollen	☐ Exercise	☐ Other:	☐ Stress/Emotions	☐ Winter ☐ Summer

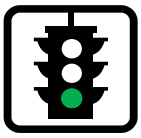
▼ Medical provider complete from here down ▼

Asthma Severity: - -

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow: _____

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ - _____

- ___ puff (s) MDI - ___ time(s) a day **Or** - _____ nebulizer treatment(s) - ___ time(s) a day

☐ (Montelukast) Singular, take 5mg by mouth once daily at bedtime

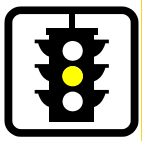
☐ Other: _____

For asthma with exercise, ADD: ☐ - _____, - ___ puffs MDI with spacer 15 minutes before ☐ PE ☐ recess ☐ sports ☐ exercise

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing



Peak flow: _____ to _____
(60% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ - _____ or _____, - ___ puffs MDI with spacer every - ___ hours as needed

☐ - one nebulizer treatment every - ___ Hours as needed for - ___ days

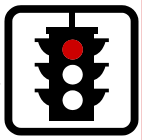
Other : _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show



Peak flow: < _____
(Less than 60% of Personal Best)

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ - _____, - ___ puffs MDI with spacer **every 15 minutes**, for **THREE** treatments

☐ - , one nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other : _____

Call your doctor while administering the treatments.
IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ **Date** _____

SCHOOL NURSE/DESIGNEE _____ **Date** _____

OTHER _____ **Date** _____

CC: ☐ Principal ☐ Cafeteria Mgr ☐ Bus Driver/Transportation ☐ School Staff ☐ Coach/PE ☐ Office Staff ☐ Parent/guardian

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

Check One:

☐ Student, in my opinion, can carry and self-administer inhaler at school.

☐ Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.

MD/NP/PA SIGNATURE: _____ **DATE** _____

Effective Dates ▶ **to ▶**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015

Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, and District of Columbia Asthma Partnership