MEDICATION ORDER TO CARRY ASTHMA INHALER

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY ASTHMA INHALER

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.*** ***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.)***
   - ***c.*** ***Medication Release of Liability form***
   - ***d.*** ***Completed Asthma Action Plan and Authorization for Medication form*** *(completed by medical provider)*

   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.*

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 ASTHMA INHALER

(This form is to be completed by the parent. 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- 04/24

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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: ____________________

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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-04/24

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name:

DOB:

School Year:

Healthcare Provider

Contact Number:

EMERGENCY CONTACT

Name: Phone:

Relationship:

Additional info:

GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

☐ **Daily Maintenance/Controller** — Day puffs — Night puffs

☐ Montelukast/Singulair ____ Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: ____ puffs (with spacer if needed) 15 minutes prior to exercise:

____ And ☐ Ipratropium ☐ Only if needed

YELLOW ZONE: Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing

Add: quick-relief medicine—to your GREEN ZONE medicines.

Your quick reliever medicine(s) is: ____ or ____

Take: ____ puffs or ☐ Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.

If your symptoms continue or return within a few hours of above treatment, take:

☐ Puffs every 4-6 hours as needed until symptoms resolve.

☐ Continue every 4-6 hours daily for ____ days.

☐ Add: ____

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.

RED ZONE: DANGER!

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

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: ____ ☐ 2 puffs ☐ 4 puffs ☐ 6 puffs or ☐ nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: ☐ in clinic or ☐ with student (self-carry).

Parent/Guardian signature ____ Date ____

School Nurse/Staff Signature ____ Date ____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

☐ Student may carry and self-administer inhaler at school.

☐ Student needs assistance & should not self-carry.

MD/NP/PA signature ____ Date ____

Approved June 2023, Virginia Asthma Action Plan Expert Group convened by the Consortium for Infant and Child Health at Eastern Virginia Medical School.

Updated August 2023