St. Theresa School Asthma Action Plan (2018-2019)

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Dear Parent or Guardian of _____:

Students with a medical condition, such as asthma, are assisted with a care plan on file at school to manage the student's condition and to assist school personnel to intervene appropriately should an asthma attack occur.

Generally, students from third grade forward can be considered able to self-administer inhalers. All inhalers must have on file the following information:

- **Physician's prescription** for the medication which includes the name of the medication, the dosage, the route, and the indications for use. A form is attached for your use or you may include an RX.
- The **inhaler** needs to have the pharmacy label on it or be stored in the appropriate pharmacy packaging.
- Parents/guardians must provide written authorization for the student to **self-administer** his/her medication and allow the student to keep the inhaler on his/her person while in school or at school related activities (such as sports and field trips). This form is attached.
- Students who self-administer their medications will submit a **"Student Agreement to Carry Inhaler"** that outlines the fact that they will never share their inhaler with another person, and that, if after proper administration of the inhaler they have not had marked improvement, will seek further intervention. This intervention would be for the student to be evaluated by a School Nurse, who would contact the parent with her findings. If the School Nurse were not available, the School Administration or Coach would then be responsible. If at any time it was felt that there was a life-threatening situation, 911 emergency services would immediately be called.

Molly Montrie, RN, BSN
STS School Nurse

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St. Theresa School
Student Agreement to Carry an Inhaler for Self-Medication (2018-2019)

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1. Student has demonstrated the correct use of the inhaler to health care provider and school health personnel.
2. Student agrees NEVER to share the inhaler with another person.
3. Student agrees that if there is not marked improvement after two puffs from the inhaler, he/she will notify a school staff member or a responsible adult who will seek further intervention as outlined in the school Asthma Management Plan.

Student Signature_____

Grade _____ Homeroom _____ Date _____

Parent/Guardian Acknowledgment

I give permission for my child _____

to carry an inhaler with the medication _____

as prescribed by his/her physician. I understand that he/she must follow the rules listed above. I will notify the school of any changes in medication or my child's condition. I also have submitted the required forms needed to allow administration of medication at school, according to Archdiocesan, St. Theresa School, and District 15 guidelines.

Parent/Guardian Signature_____ Date_____

To be updated by parent/guardian/physician annually

Physician's Order

Student _____ Grade _____

_____ _____ _____

Medication/ Health Care Treatment Dosage Time(s) to be administered

_____ _____

Intended effect of this medication Expected side effects, if any

_____

Other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY:**
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

Physician's/ Prescriber's Name (PRINT) Emergency telephone number

_____

Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____,
(Please circle one)

20 ___, by _____ on behalf of
Signature of Principal

_____ School, _____ , Illinois

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To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

Student Name (Last, First, Middle)	Date of Birth	Grade	Date
_____	_____	_____	_____

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

_____ Parent/Guardian (PRINT)	_____ Parent/Guardian (PRINT)
_____ Parent/Guardian (SIGNATURE)	_____ Parent/Guardian (SIGNATURE)
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Home Phone Business Phone	_____ Home Phone Business Phone