ASTHMA

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Dear Parent/Guardian:

We would like to inform you of the school policies that have been in place to ensure the health, safety and welfare of children who need medicine during the school day. Our school board requires that the following forms must be on file in your child's health record before we begin to give any medicine at school.

1. Consent from signed and dated by parent or guardian.
2. Medication order form filled out, signed, and dated by child's doctor.
3. Emergency plan filled out, signed and dated by parent.
4. Call school nurse for appointment time before reporting to the school.

When your child needs medication to be given during the school day, please refer to these simple rules to help make it a more pleasurable experience.

1. Medication must be brought in by a parent/guardian only. **No students are allowed to bring medication onto campus**. Only a 35 day supply of medicine will be accepted.
2. Each school has a designated time of receiving medication. Please check with your child's school personnel for these times.
3. Each school has designated times for given medications; please help the school personnel by following this policy.
4. Antibiotics, skin creams, pain medicine, or a.m. doses will have to be approved by the school nurse prior to administering in schools.
5. All doctor's orders and medicine bottle labels must match.
6. **Must meet with school nurse before medication can be given (exception: asthma inhalers and epi pens)**

I have read and understand the above rules that must be complied with for my child to receive medications at school.

_____ _____
Parent's/Guardian's Signature Date

Thank you for your cooperation in helping us give your child's medicine safely.

_____ Alvado C. Willis
School Nurse's Signature Alvado C. Willis, Special Education Director

ST. LANDRY PARISH SCHOOL BOARD
PARENT/GUARDIAN WRITTEN REQUEST AND CONSENT
FOR MEDICATION ADMINISTRATION

General Information

Name of Student: _____ School: _____
Date of Birth: _____ Sex: _____ Grade: _____ Teacher_____
Name of Parent / Guardian: _____
(Please Print)
Telephone Number – (Home) _____ (Work) _____
Telephone Number – (Where parent/guardian can be reached in case of emergency):_____
Other Persons to be notified in case of emergency if parent/guardian is unavailable:
Name:_____ Telephone:_____
Relationship:_____
Name:_____ Telephone:_____
Relationship:_____

My son / daughter is currently receiving the following medications: Please list all medications the child is receiving, including those given during the school day:
1._____ 2._____ 3._____ 4._____

My son / daughter is known to have the following allergies: _____

********** **********

Consent

1. I hereby give permission for the school nurse or the designated unlicensed school personnel to give the following medicine:_____ prescribed.
(Name of Medication)

_____ _____
(Licensed Prescriber) (Name of Student)

2. I give permission for my son / daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school: Yes _____ No____

I acknowledge that the St. Landry Parish School Board and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of medications used to treat asthma or anaphylaxis. The parent or legal guardian shall indemnify and hold harmless the St. Landry Parish School Board and its employees against any claims that may arise relating to the self-administration of medications used to treat asthma or anaphylaxis. (***Health and Safety, Bulletin 135, Louisiana Department of Education***)

Signature of Parent/Guardian: _____
Signature of Student: _____

3. I give permission to the school nurse to obtain information relative to the prescribed medication from the above named physician and share it with appropriate school personnel (such as adverse effects).
Yes ___ No ___ Restrictions on release: _____

4. **I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication.**
Yes___ No___

5. I understand if there is a change in physicians, the medication order is no longer valid:
Yes___ No___

(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or _____ beyond the close of school.)

Signature of Parent / Guardian _____

Relationship to Student _____ Date:_____

ST. LANDRY PARISH SCHOOL BOARD
SCHOOL NURSE PROGRAM
UNAVAILABLE MEDICATION TIMES

Date: _____

Student Name: _____

Date of Birth: _____

MD: _____

Please be aware that medications are unavailable after the school office closes and on the school bus (including Diastat®, Epi-Pens, Glucagon, and Inhalers), unless the student has orders to self-carry & administer medication without supervision.

_____ _____

Licensed Provider's Signature Date

_____ _____

Parent Signature Date

_____ _____

RN Signature Date

STATE OF LOUISIANA
ASTHMA MEDICATION ORDER
TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name: _____ DOB: _____

School: _____ Grade: _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature: _____ Date: _____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____ Strength of medication: _____ Dosage (amount to be given): _____
4. Administer _____ Puffs Every _____ For Complaints of:

    1. difficulty breathing
    2. wheezing
    3. coughing
    4. shortness of breath
    5. tightness in chest
    6. skin color changes

5. May repeat dosage in _____ minutes if no relief obtained and still showing any signs and symptoms of above (#'s 1-6).

    If relief obtained, call parents and inform them of repeat dosage.

    If no relief after second dose and/or if child stops breathing or loses consciousness:
    Do the following: 1. Call Ambulance – 911
    2. Call Parents

6. Duration of medication order: ❑ Until end of school term ❑ Other _____
7. Desired Effect: _____
8. Possible side-effects of medication: _____
9. Restrictions (if any i.e., P.E.) _____
10. Any contraindications for administering medication: _____
11. Next visit is: _____

Licensed Prescriber's Name (Printed) Address Phone and Fax Numbers

Licensed Prescriber's Signature Credential (i.e., MD, NP, DDS) APRN # Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE

Inhalants / Emergency Drugs
Release Form for Students to be Allowed to Carry Medication on His/Her Person
Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration? ❑Yes ❑No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑Yes ❑No

Licensed Prescriber's Signature Credential (i.e., MD, NP, DDS) APRN # Date

ASTHMA ACTION PLAN

Name:	Date:
Doctor :	School Nurse:
Doctor's Phone #:	
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

GO

You have all of these:

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

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have all of these:

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

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
CALL YOUR ASTHMA CARE PROVIDER		

DANGER

You have all of these:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

***This form does not replace the Louisiana Medication Order Form.**
***This form constitutes for a plan of care for the student in the school setting.**

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PUPIL APPRAISAL CENTER
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Activity Restrictions

Date: _____

Student's Name: _____

Medical Condition: _____

Can the student participate in Physical Education Classes?
____Yes ____No

Are there any activity restrictions for this student?
____ Yes ____No

What are the student's limitations/restrictions? Please list them:

_____

_____

_____

_____ _____
Physician's Name (Print) Physician's Signature

_____
Physician Address

_____ _____
Telephone Number Fax Number

Thank you for your time and assistance in completing this documentation.

St. Landry Parish School Nurses

St. Landry Parish School Board
Emergency Health Care Plan: Asthma

Name_____ Age _____Grade_____ School _____
Diagnosis of student: _____ Age at time of diagnosis _____
Date of child's last asthma attack – (**month/date/year)**:_ __/__ __/_____.

IF YOU SEE THIS	**DO THIS**
Wheezing Excessive coughing Shortness of breath/trouble breathing Rapid Breathing Flaring nostrils Increase use of stomach/chest while breathing Tightness in chest Unable to speak in full sentences	If available, refer to student's emergency care plan. Administer doctor/parent/guardian approved medication, Have student sit quietly Have student breath slowly and deeply Maintain cool environment Remain calm, Encourage relaxation Notify parents, possibly send student home. Notify school administration. If a child is so uncomfortable that he/she is unable to participate in school activities, contact responsible school authority and parent or legal guardian.
No improvement with medication/or Getting worse /or Breathing difficulty develops rapidly	If Available, refer to student's emergency care plan. Administer Doctor and Parent/Guardian approved medication. Call Emergency Medical Systems-(911) Contact responsible school authority & parent/guardian/school nurse **LOOK LISTEN AND FEEL FOR BREATHING. IF CHILD STOPS BREATHING-BEGIN CPR.**
Difficulty Breathing-Walking, Talking. Blue or Gray discoloration of fingernails, lips, or tongue	Call 911 Contact responsible school authority & parent/guardian/school nurse.

Poison Control # - <u>1-800-256-9822</u>

<u>Emergency Information</u>:
Parents or Guardian's Name: _____
Phone number: Home _____ Work _____ Cell _____

Alternate Adult Contact Name: _____
Phone number: Home _____ Work _____ Cell_____

Physician's Name _____ Phone number _____

Student's Allergy History _____ Latex allergy: YES__ NO__
(List all medications, foods, plants, insects, etc. that your child is allergic to)

The following staff members are trained to deal with an emergency and to initiate the appropriate procedures.
1._____2._____3._____
4._____5._____6._____

I have reviewed this emergency health plan for allergic response. I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room. **<u>I will be responsible for payment of emergency care.</u>**

Signature of Parent/Guardian _____ **Date** _____

School Nurse _____ **Date** _____

ST. LANDRY PARISH PUPIL APPRAISAL CENTER
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LOUISIANA 70570

Questionnaire for Parents of Child with Asthma

Student's Name_____ **School Year**_____

School_____ **Grade**_____ **Teacher**_____

Parent's Name_____ **Telephone (home)**_____ **(work)**_____

Name of Child's Doctor (for asthma)_____ **Telephone**_____

Does your child ride the school bus? ___yes ___no Bus#_____ Driver's Name_____

The following information is helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. How long has your child had asthma?_____

2. Please rate the severity of his/her asthma. (Circle)

   (not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

3. How many days would you estimate he/she missed school last year due to asthma?_____

4. What triggers your child's asthma attacks? (Please check any and all that apply)

   _____Illness _____Emotions _____Medications _____Foods
   _____Weather _____Exercise _____Fatigue _____Chemical odors
   _____Cigarette or other smoke

   ALLERGIES (please list)_____
   Other (please list)_____

5. What does your child do at home to relieve wheezing during an asthma attack?
   (Please check any that apply.)

   ___Breathing exercises Takes medication: ___Inhaler
   ___Rest/relaxation ___Nebulizer
   ___Drinks liquids ___Oral medication
   ___Other (please describe)_____

6. Please list the medications your child takes for asthma (every day and as needed)

	Name of Medication	Dose	Frequency
(In School)			
(At home)			

7. What, if any, side effects does your child have from his/her medication?

_____

8. Has your child been taught how to use an extension tube, pulmonary aid, inspirease kit or other device with his/her inhaler? ___Yes ___No

9. How many times has your child been hospitalized overnight or longer for asthma in the past year?_____

10. How many times has your child been treated in the emergency room for asthma in the past year?

_____

11. How often does your child see his/her doctor for routine asthma evaluations?_____

12. Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly)

Modified gym class_____
Modified recess outside_____
No animal pets in classroom_____
Avoiding certain foods_____
Emotional or behavior concerns_____
Special consideration while on field trips_____
Observation for side effects from medication_____
Other_____

13. Do you think your child is held back from participation in all activities at school because of his/her asthma? If so, please describe.

_____

_____

14. Have you ever attended an asthma education class? ___Yes ___No

Has your child had asthma education? ___Yes ___No

15. Will your child require medication at school for his/her asthma (i.e., Asthma Inhaler)? ___Yes ___No

***If you answered **yes** to question number 15, please obtain an asthma medication packet from school. The physician and parent/guardian will need to complete the proper paper work and sign in the medication at school. Instructions are included in the packet.

Thank you for your time and assistance in assessing your child's special needs in school