School Year: _____

TUSSEY MOUNTAIN SCHOOL DISTRICT
Medication Permission Form

It is the procedure of the Tussey Mountain School District to administer prescribed medication during school hours only when absolutely necessary for the health of the student.

- All medication given MUST have a **parent and physician permission slip** to be given at school.
- Medication must come to school by a parent/guardian in a **prescription bottle** labeled with the child's name, medication name, dose, and time to be given.
- Students are **not permitted** to transport medication to or from school (unless previously authorized by the school nurse).
- A separate form must be completed for EACH medication required at school.

To be completed by the PARENT

Name of Child: _____

By signing below, I give permission to the school nurse, or other designated person, to administer the medication to my child, named above, in accordance with the physician's instructions. I also give my permission for the school nurse to communicate with my child's physician in regards to this medication/treatment. I release, and hold harmless the Tussey Mountain School District employees from any and all liability and claim whatsoever for the administration of this medication to my child. I understand that this medication must be furnished to the school in accordance with district policy.

Parent Signature: _____ Date: _____

To be completed by the PHYSICIAN

Student Name: _____

Diagnosis: _____

Medication name: _____

Strength/Dosage: _____

Route to be given: _____ **Time to be given:** _____

Possible side effects: _____

Duration of medication administration: _____
(all orders expire at the end of the current school year)

Other instructions: _____

For Epi-Pen or Inhalers only:

I request this student be allowed to carry and self-administer his/her **Asthma Inhaler** ☐ Yes ☐ No
I request this student be allowed to carry and self-administer his/her **Epinephrine Auto-Injector** ☐ Yes ☐ No

As the health care provider for this student, by signing below I verify that he/she has been taught proper use of his/her inhaler/ epinephrine auto-injector, has adequate knowledge of asthma/anaphylaxis and how to control it, and is thought to be responsible enough to carry his/her inhaler/ epinephrine auto-injector, and can self-administer properly without supervision.

Physician's Signature: _____ **Date:** _____

Printed name of Physician:_____**Phone:** _____

Completed form may be faxed to the school nurse at 635-3184

Tussey Mountain School District

School Year: _____

Asthma - Action Plan

Student Name:	Grade/Homeroom:
Describe type/severity of asthma:	
Emergency Contacts- Name and Numbers:	

Triggers Include: Check all that apply			☐ List ALL medications- name, dose, & frequency
☐ Weather	☐ Dust	☐ other (describe)	_____
☐ Exercise	☐ Food	_____	_____
☐ Animals	☐ Pollen	_____	_____
☐ Smoke	☐ Colds/Illness		_____

Is inhaler needed prior to physical activity? (circle answer) YES NO

If Yes- Medication Name _____ to be given _____ minutes prior to activity.

IF YOU SEE THE FOLLOWING SYMPTOMS

Symptoms of an **Asthma Episode** may include: (Please add any other symptoms your child may exhibit)

Breathing Changes	**Student Reports:**	**Student Appears:**
Coughing, Wheezing, Shortness of breath, mouth breathing, _____	Chest tightness or pain, can't catch breath, feels funny, not feeling well, speaks softly, _____	Anxious, Sweating, Nauseated, Fatigued, Stands hunched and can't straighten easily, _____

DO THIS:

1. Stop activity immediately. Accompany student to nurse's office, or call for nurse if student unable to walk.
2. Help student assume a comfortable position. Sitting up is usually more comfortable.
3. Encourage pursed-lipped breathing.
4. **Give medication as ordered by doctor. Give (medication name)_____ (number)_____ puffs inhaled. May repeat in _____ (time) if no improvement of symptoms.**
5. Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, Notify parent/guardian and follow steps below for an emergency. If symptoms resolve, student will be able to return to class.

IF YOU SEE THE FOLLOWING SYMPTOMS

Symptoms of an **ASTHMA EMERGENCY:**

Labored or Ineffective breathing	Blue-gray discoloration of lips and/or fingernails.
Nose opening wide with inhales	Failure of medication to reduce symptoms
Heart Rate greater than 120/minute	Respirations greater than 30/minute

DO THIS:

1. Call for nurse if not already on scene. If no nurse is available, proceed to next step.
2. Call 911 and inform them that you have an asthma emergency. Provide any information they request.
2. Stay with student. Contact nurse and prinicpal
3. A staff member (designated by the principal) should accompany the student to the emergency room if the parent, or emergency contact is not present. Preferred Hospital if transported: _____

By signing below, I authorize school personnel to implement this asthma action plan as described above. I also understand staff may be notified about the respiratory condition to help maintain my child's health and safety at school. I further understand that all costs of emergent medical treatment provided shall be my sole responsibility as the student's parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Reviewed and approved by:

School Nurse Signature: _____ Date: _____

Physician Signature: _____ Date: _____