

Individualized Student Asthma Action and Care Plan for the _____ School Year

Student Name: _____ DOB: _____ Grade: _____

Allergies: _____ Medications: _____

School: _____ HR Teacher: _____

The following is to be completed by the PHYSICIAN:

CLASSIFICATION OF CONTROL	TRIGGERS
<input type="checkbox"/> Well Controlled <input type="checkbox"/> Not Well Controlled <input type="checkbox"/> Very Poorly Controlled	<input type="checkbox"/> Colds <input type="checkbox"/> smoke <input type="checkbox"/> Tobacco <input type="checkbox"/> Exercise <input type="checkbox"/> Dust <input type="checkbox"/> Pesticides <input type="checkbox"/> Weather <input type="checkbox"/> Air Pollution <input type="checkbox"/> Animals <input type="checkbox"/> Birds <input type="checkbox"/> Mold <input type="checkbox"/> Cleansers <input type="checkbox"/> Perfume/strong odors <input type="checkbox"/> Cockroaches <input type="checkbox"/> Other _____



Is Medication Needed For This Student Prior To Exercise?
 15 Minutes before exercise, please give the following:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 1 Cough, Wheezing, Chest Tightness, or Some Problems Breathing

Please give the following & inform parent/guardian:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 2 If Worse (Symptoms Not Improving)

Please give the following & inform parent/guardian if it has been at least _____ since last dose:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 3 Severe Symptoms (Severe Difficulty Breathing ▪ Trouble Walking or Talking Due to Asthma Symptoms ▪ Quick Relief Medicine Has Not Helped ▪ Lips or Fingernails Blue or Gray)

Activate Emergency Plan:

- 1. Call for 911 for an ambulance AND**
- 2. Contact the parent / guardian AND**

*Give the following **Now** if it has been at least _____ since last dose:*

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

_____ Physician Signature	_____ Physician Name	_____ Phone Number	_____ Date
_____ Parent Signature	_____ Parent Name	_____ Phone Number	_____ Date
_____ LCHD RN Signature	_____ LCHD RN Name	_____ Phone Number	_____ Date

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the **Healthiest State** in the Nation

Florida Department of Health in Leon County
CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year _____

Student's Name: _____

DOB: _____

School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

- ___ Leon County School District
- ___ Tallahassee Memorial Hospital Diabetes Center
- ___ Children's Medical Services
(Name of case manager: _____)
- ___ Florida Department of Health in Leon County (Health Department)
- ___ Tallahassee Pediatric Foundation
- ___ Primary Physician _____
(Please fill in Physician name)
- ___ Specialist Physician _____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

Signature

Date

Florida Department of Health
in LEON COUNTY • School Health
2965 Municipal Way • Tallahassee, Florida 32304
PHONE: 850/606-8183 • FAX 850/487-7954

www.FloridasHealth.com
TWITTER: HealthyFLA
FACEBOOK: FLDepartmentofHealth
YOUTUBE: fldoh

ACCEPTING MEDICATION FROM PARENTS –FAQ’S

- Prescribed medications required to be given during school hours will be accepted.
- Over-the-Counter (OTC) medications will be accepted and administered for temporary medical conditions for a period no longer than 5 calendar days, and cannot be renewed beyond 5 days without a healthcare provider’s written authorization.
- All medications must be transported to and from school by a parent, legal guardian, or designated adult.
- Before assisting any student with medication, a Medication Permission Form must be completed and signed by a parent or legal guardian.
- A separate Medication Permission Form must be completed for each medication, and is valid for the current school year in which it is completed (prescription medications only).
- All medications must be in the original container or packaging, and must contain labeled dosing instructions.
- Medication and doses of medication must be age-appropriate. Some non-prescription medications are not recommended for children. Check the box/bottle for this information.
- Before leaving medications at school, all medications must be counted, verified and documented by the parent / guardian and staff member on the Medication Log.
- Medications containing aspirin (Excedrin, Goody Powder, etc.) will not be accepted without a physician’s written order, due to the association with Reye Syndrome.
- Only FDA-approved medications will be accepted. No vitamins, nutritional supplements, etc.
- Parents / Guardians may not change the dose or time of administration of any prescription medication. A physician’s written order or new prescription bottle reflecting the change is required.
- Completed Medication Permission Forms must match the prescription or OTC dosing instructions.
- Students who carry medications allowed by Florida Statutes must have a completed Medication Permission Form and a written order from the physician to carry the medication on file in the school clinic.