Individualized Student Asthma Action Plan for the 20___ - 20___ School Year

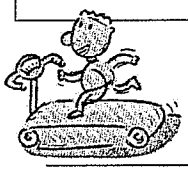
Student Name:_____ DOB:_____ Grade: _____

Allergies:_____ Medications:_____

School:_____ HR Teacher: _____

The following is to be completed by the PHYSICIAN:

CLASSIFICATION OF CONTROL	TRIGGERS
☐ Well Controlled ☐ Not Well Controlled ☐ Very Poorly Controlled	☐ Colds ☐ smoke ☐ Tobacco ☐ Exercise ☐ Dust ☐ Pesticides ☐ Weather ☐ Air Pollution ☐ Animals ☐ Birds ☐ Mold ☐ Cleansers ☐ Perfume/strong odors ☐ Cockroaches ☐ 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 ☐ IHP

5/14

LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT
(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____(first/last name), _____(date of birth), to be given the medication or treatment listed below during the school day, including when she/he is away from school property on official school business. I hereby authorize the School Board of Leon Count, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors, and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication (s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning date: _____ Ending date: _____ Amount of liquid or count of pills: _____

Emergency telephone numbers:

Parent/Guardian: _____ H: _____ C: _____

Parent/Guardian: _____ H: _____ C: _____

Doctor's name: _____ Doctor's Phone Number: _____

Prescription and over-the-counter medications/treatments shall come in the original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered for **five calendar days** without a signed licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy.

Parents are responsible for safe delivery of medication to the school (students may NOT transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC, and any of their officers, employees, contractors, and agents from any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____

Date Parent/Guardian Signature

_____ _____

Date RN Signature

Leon County Schools

AUTHORIZATION TO CARRY MEDICATION(S) PERMITIED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify)

Medication and/or Supplies: _____

_____

Dosage/instructions: _____

_____

Diagnosis: _____

_____	_____	_____	_____
Physician Signature	Physician Name	Phone Number	Date

I have read and understand the waiver of liability statements on the Authorization for Medication and feel that my child is capable of self-management and administration of the above medication/supplies.

_____	_____	_____	_____
Parent Signature	Parent Name	Phone Number	Date

*** For staff use only***

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

_____	_____	_____	_____
FDOH RN Signature	FDOH RN Name	Phone Number	Date

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)

____ [X] Leon County School District
____ [ ] Tallahassee Memorial Hospital Diabetes Center
____ [ ] Children's Medical Services
(Name of case manager: _____)
____ [X] Florida Department of Health in Leon County
____ [ ] 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.

_____ _____

Parent/Guardian Signature Date