

Asthma Care Plan and Medical Authorization

Student: _____ DOB: _____ Teacher: _____ School: _____ Grade: _____ Parent: _____ Phone: _____

TRIGGERS: Please check if applicable

<input type="checkbox"/> Exercise <input type="checkbox"/> Animal Dander Type: _____	<input type="checkbox"/> Colds (Viral illness) <input type="checkbox"/> Cold Air (weather changes) <input type="checkbox"/> Pollens (Trees, grasses, weeds)
<input type="checkbox"/> Emotions (Excitement, anxiety, grief, tension) <input type="checkbox"/> Irritants (Chalk, cleaning solvents, cigarette smoke, strong odors)	
<input type="checkbox"/> Molds <input type="checkbox"/> Dust <input type="checkbox"/> Others (Specify) _____	

<p>GREEN ZONE Peak Flow Between _____ - _____</p> <p>GOOD CONTROL</p> <ul style="list-style-type: none"> ▪ No or rare coughing/wheezing ▪ Easily tolerates activity 	<p style="text-align: center;">PLAN</p> <p>Daily meds given at home:</p> <p>1) _____</p> <p>2) _____</p> <p>At school may use _____ puffs every _____ hours PRN for wheezing, SOB, or cough</p> <p>Other: _____</p>
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<p>YELLOW ZONE Peak Flow Between _____ - _____</p> <p>WORSENING ASTHMA</p> <ul style="list-style-type: none"> • Frequent coughing • Short or labored breathing • Increased shortness of breath with activity • Using inhaler more frequently 	<p style="text-align: center;">PLAN</p> <ul style="list-style-type: none"> ▪ Use _____ inhaler _____ puffs every _____ hrs as needed for wheezing, cough, SOB ▪ Repeat in _____ minutes if no relief ▪ Other _____ ▪ Notify parent _____ ▪ STAY WITH CHILD
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<p>RED ZONE Peak Flow Between _____ - _____</p> <p>DANGER ZONE</p> <ul style="list-style-type: none"> ▪ Getting poor relief from inhaler ▪ Increasing breathlessness in spite of meds ▪ Turning blue w/rapid short breaths ▪ Incessant coughing or wheezing 	<p style="text-align: center;">PLAN</p> <ul style="list-style-type: none"> ▪ Use urgent medications as follows: 1) _____ 2) _____ ▪ Call parents to come immediately ▪ Call 911 if symptoms continue or worsen
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I certify this student is competent to carry and safely self-administer this medication. _____ *Physician's Initials If YES

Location of Medication: Locked med cabinet in Health Office Backpack Other _____

Field Trip Info: Medication used at school must accompany student on ALL field trips. A copy of this Healthcare Plan and current phone numbers should be with the supervising staff member.

*Physician Signature: _____	Date: _____
Physician's License Number: _____	Phone: _____
School Nurse Signature: _____	Date: _____

VISTA UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION
(Education Code-Section 49423)

Any pupil who is required to take, during the regular school day, medication prescribed for him by a health care provider, may be assisted by the school nurse or other designated school personnel if the school district receives:

- 1) A written statement from such health care provider detailing the method, amount, and time schedules by which such medication is to be taken. See the reverse side of this form.
- 2) A written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the health care provider's statement. See authorization statement below.

This authorization is valid only for the current school year. If any of the conditions in the health care provider's statement change, parent/guardian must notify the school nurse and a new form must be signed by the parent/guardian and the provider. The parent/guardian may submit a written statement rescinding consent for administration of medication at school at any time. Parent/guardian will inform the school nurse of any changes in the student's health status or health care provider.

Only medication prescribed by the pupil's authorized health care provider as being necessary to be taken by the pupil in the manner listed on the provider's statement should be brought to school. Medication should be in original containers which are clearly marked with the name of the pupil, the name of the medication, and the amount of the medication.

This portion to be completed by the parent/guardian.

I request that a school nurse or other district designee administer the medication as directed by the health care provider on the reverse side of this form to my child:

Pupil's Name _____

I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

I consent for the school nurse or site administrator to communicate with the authorized health care provider and pharmacist with regard to the provider's written statement for administration of medication at school.

Signature of Parent/Guardian _____

Date _____

Work Telephone Number/Home Telephone Number _____

DISTRITO ESCOLAR UNIFICADO DE VISTA

AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS
(Sección 49423 del Código de Educación)

Cualquier alumno(a) que necesite tomar, durante el día escolar, un medicamento recetado por un médico para él/ella, puede ser asistido(a) por una enfermera escolar u otro empleado escolar designado si el distrito escolar recibe:

- 1) Una declaración escrita de dicho medico detallando el método, cantidad y horario a seguir para administrar dicho medicamento. Refiérase a la parte de atrás de este formulario.
- 2) Una declaración escrita de parte de los padres o tutores del alumno indicando que desean que el distrito escolar asista al alumno(a) a llevar a cabo lo indicado en la declaración médica. Refiérase a la declaración de autorización a continuación.

Esta autorización únicamente es válida durante el presente año escolar. Si algunas de las condiciones contenidas en la Declaración Médica cambian, un formulario nuevo debe ser firmado por los padres/tutores y el medico.

Únicamente los medicamentos que el médico le prescribió al alumno que se necesitan administrar al alumno de la manera enumerada en la Declaración Médica deben traerse a la escuela. El medicamento debe estar dentro de un envase que esté identificado con el nombre del alumno, nombre del doctor que prescribe el medicamento, y la cantidad del medicamento.

Esta parte debe ser llenada por los padres/tutores.

Yo solicito que una enfermera escolar u otro representante del distrito, le administer a mi hijo(a) el medicamento según las instrucciones del medico, contenidas en la parte de atrás de esta hoja:

Nombre del alumno _____

Yo reconozco el hecho de que este es un servicio o favor que la escuela no tiene que realizar legalmente. Yo estoy de acuerdo con mantener al distrito, sus oficiales, empleados o agentes, libres de cualquier responsabilidad, demandas o quejas de cualquier naturaleza o especie, que puedan suscitarse como resultado de la administración del medicamento conforme a esta solicitud.

Firma de los padres/tutores _____

Fecha _____

Número de teléfono del trabajo/Número de Teléfono de la casa _____