ZEELAND CHRISTIAN SCHOOL

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT / GUARDIAN

Student's Photo

I, the parent/guardian of _____ DOB _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent/guardian, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours
   And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes
4. I will assume responsibility for safe delivery of the medication to school
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I give permission for my child to self administer rescue medication if approved by physician
7. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization

PLEASE COMPLETE ATTACHED ASTHMA ACTION PLAN, OR SUBMIT A CURRENT PLAN ALREADY ON FILE IN PHYSICIAN OFFICE.

I have discussed and developed a plan, with the school nurse, for appropriate support during school emergencies.

Signature of Parent/Guardian: _____Relationship: _____

Date: _____Emergency Contact Phone #_____

ZEELAND CHRISTIAN SCHOOL
334 W. Central Ave., Zeeland, MI 49464, Phone: (616)772-2609, Fax: (616)772-2706

SELF-ADMINISTRATION OF INHALER STUDENT AGREEMENT

This order is valid for the school year (current) _____, including the summer session.

Student Name: _____ Date of Birth: _____Grade: _____

To be Completed by the Student:

I agree to:

- Follow my prescribing healthcare provider's medication orders.
- Carry my medication in its original container properly labeled with my name, the medication name, the medication dose and frequency of administration, the ordering physician's name and a current date (unexpired) for all prescription medications, or an intact label and current date for all non-prescription medications, with my name written on the label. ● Carry a copy of my individualized healthcare plan with the medication.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and all field trips.
- Notify the school nurse if:
    - My symptoms continue or get worse after taking my medication.
    - My symptoms recur within 2-3 hours after taking my medication.
    - I think I might be experiencing side effects from my medication.

I understand that permission for self-carry/self-administration of my medication may be discontinued if I am unable to follow the safeguards established above.

Signature of Student:_____Date:_____

For use by the Nurse:

Student verbalizes correct dosage of medication

Student able to verbalize asthma symptoms

Student is carrying medication appropriately with a copy of the individualized healthcare plan

Student demonstrates proper technique for medication administration.

For Inhaler:

1. Removes cap and shakes if applicable
2. Attaches spacer
3. Breaths out slowly
4. Presses Inhaler to release medication
5. Inhales slowly
6. Holds breath for 10 seconds
7. Repeats in 1 minute or as directed

Student verbalizes safe use of inhaler (not sharing, when to come to the nurse's office)

School RN: _____ Date: _____

Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION®

Name _____ DOB ____/____/_____

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Please send a signed copy back to the provider listed above.