

Location of
Inhaler: _____

**Loudoun County Public Schools
Asthma Action Plan/Physician's Order**

Place
Student's
Picture
Here

STUDENT'S NAME: _____ DOB: _____ GRADE: _____
School: _____ Homeroom Teacher: _____ Room # _____
Transportation: Walker _____ Car _____ Bus # _____

Identify asthma triggers (Circle each that applies to this student)

Exercise Pollens Change in temperature
Respiratory infections Molds Other _____

To Be Completed by Healthcare Provider: for Medications to be Administered at School

Medication	Amount	Frequency	When to Use (PRN, Pre PE, Pre Recess)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

If more than one medication is to be given at the same time, list in order to be given.

SEEK EMERGENCY MEDICAL CARE (911) IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No Improvement 15-20 minutes after initial treatment.
- Breathing is hard and fast with difficulty walking, talking or eating.
- Lips or fingernails are gray and blue accompanied by fatigue, weakness.
- Difficulty breathing with chest and neck pulled in.
- Audible wheezing may have subsided.

Interval for Repeating Dosage:

If symptoms not relieved after initial dose: _____
If symptoms reoccur before next dose is due: _____

Should student carry his/her asthma medication? Yes No (circle one)

Healthcare Provider's Signature: _____ Date: _____
Healthcare Provider's Printed Name/Stamp: _____
Phone Number: _____ Fax Number: _____

To Be Completed by Parent/Guardian:

Parent/Guardian Name: _____ Phone: _____
Parent/Guardian Name: _____ Phone: _____
My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.
Parent/Guardian Signature: _____ Date: _____

To Be Completed with Health Office Staff:

Medication received by: _____ Date: _____
Health Office Staff Signature
Medication picked up by: _____ Date: _____
Parent/Guardian Signature

Loudoun County Public Schools
Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Asthmas Action Plan)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic specialist.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering the medication, I will report to the school nurse/health clinic specialist or another appropriate adult if the nurse/health clinic specialist is not available or present.

Student's Signature Required

Date

Parent Information About Medication Procedures

1. **Medications should be taken at home** whenever possible so that the student does not lose valuable classroom time.
2. If it is absolutely necessary for the student to take medication at school, this **"Authorization for Medication Administration"** form must be received for each medication and must be submitted to the Health Office staff prior to the medication being given at school. Use the appropriate **Action Plan** for asthma, allergy, seizure and diabetes medications. Medication will not be accepted without receipt of the appropriate form.
3. **The Health Office staff must have written instructions from the healthcare provider in order to administer prescription medications.** The "Authorization for Medication Administration" form is preferred, but the healthcare provider may use office stationary or a prescription pad with the following information:
 - Student's name and date of birth
 - Name and purpose of medication
 - Dosage, time & route of administration
 - Duration of medication order/effective dates
 - Possible side effects/actions to take if these occur
 - Healthcare provider signature/date
4. **Medications must be brought to the Health Office by a parent/guardian** (LCPS 8-36 policy). Students with diabetes, asthma, or life-threatening allergies may carry life-saving medications (insulin, Glucagon, inhaler, Epinephrine Auto-Injectors) throughout the school day with the approval of the physician, school nurse and parent/guardian as indicated on the "Physician Order/Health Care Plan." Otherwise, students are not permitted to transport medications to and from school or carry any medication while in school.
5. **Medication Containers:**
 - ❖ Prescription medications- must be in the original pharmacy bottle with proper label containing:
 - Student's name
 - Name of Medication
 - Time to be given
 - Dose/amount to be given
 - Healthcare Provider name
 - ❖ Non-prescription medications (OTC- over-the-counter)- must be in the original package with the name of the medicine and instructions.
6. Prescription information on bottle label must match the healthcare provider information on the "Authorization for Medication Administration" form. Ask the pharmacy to provide a properly labeled bottle for school.
7. Staff will not cut/break pills. Parents/Guardians should cut/break pills or request the pharmacy to cut pills into the correct dose.
8. **The first dose of any NEW medication must be given at home.**
9. Medications will be given no more than 30 minutes before or after the prescribed time.
10. Non-prescription medication will only be administered according to directions on the label. If a higher dosage is required, the "Authorization for Medication Administration" form must be signed by the healthcare provider.
11. Medication kept at school will be stored in a locked area of the Health Office accessible only to authorized school personnel.
12. The student is to come to the Health Office or to a predetermined location, at the prescribed time to receive medication. Parents should develop a plan with the student to ensure that the student goes to the Health office at the appropriate time.
13. A new "Authorization for Medication Administration" form is required at the start of the school year and each time there is a change in the dosage or time at which a medication is to be taken.
14. Parents/Guardians should not bring in more than a 60-day supply of prescription medicine at a time.
15. Any **herbal or natural alternative medications** (botanicals, oils, dietary or nutritional supplements, homeopathic medicine, phytomedicinals, vitamins, and minerals) require an "Authorization for Medication Administration" form signed by the healthcare provider and parent/guardian.
16. **Unused medications MUST be picked up by a parent/guardian on or before the last day of school or it will be destroyed.**