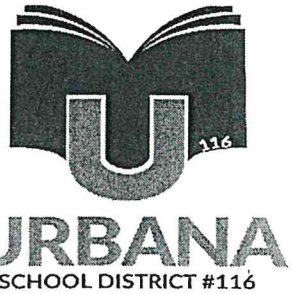
URBANA SCHOOL DISTRICT 116

Jean F. Burkholder Administrative Service Center
1101 E. University Ave., Suite B
Urbana, IL 61802
www.usd116.org



Dr. Jennifer Ivory-Tatum
Superintendent

Dear Parent/Guardian,

We would like your assistance in providing support for your student with asthma. Please talk with your students Healthcare Provider regarding the need for an **Asthma Action Plan.** An Asthma Action Plan provides an *individualized* outline/explanation to school staff, including the Building Nurse, on how to safely respond to your students' health needs. To implement an Asthma Action Plan for your child, please complete the attached forms with assistance from your students Healthcare Provider, and *return to the Main Office or Building Nurse at your students school*:

- ☐ **Asthma Action Plan**
- ☐ **Medication Authorization Form(s)**
  (Please fill out a separate Authorization Form for each type of Medication)
- ☐ **Authorization for Use and Disclosure of Protected Health Info. & Education Records**

If an **Asthma Action Plan** is *deemed NOT necessary* by your students Healthcare Provider we understand you may like for your child to carry and self-administer their asthma medication while at school. In order to accommodate this, please complete the attached form and *return to the Main Office or Building Nurse at your students school*:

- ☐ **Self-Administration of Asthma Medication Authorization Form**

1. **Please Note:** If you are requesting your child be allowed to carry and self administer their reliever/rescue inhaler, a current ***prescription label*** may be submitted ***instead*** of a written order from your child's Healthcare Provider. The prescription label **must** contain the following 3 details:
   a. name of the medication
   b. the prescribed dosage
   c. time at which or circumstances under which the medication is to be administered
2. Asthma medication **must** be in the correctly labeled prescription container
3. We recommend an additional dose of asthma medication be kept at school for your child's protection in case it is needed and she/he has forgotten or misplaced their medication.
4. It will be your responsibility to remind your child to make sure they have their asthma medication when attending *before and after school activities*, or when *leaving the school campus for any reason*, including *field trips.*

We appreciate your cooperation in helping us to provide for the safety and health of your child while in school. Please contact your Building Nurse or the District Nurse at (217)-384-3549 if you have any questions or concerns.

Sincerely, Amy Marx RN | District Nurse

American Lung Association.

Asthma Action Plan

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
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – 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 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are 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 _____

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

- USD#116 MEDICATION AUTHORIZATION / RELEASE FORM -

To be completed by Parent/Guardian:

Students Name _____ Birth Date _____

Address _____ School _____

Teacher _____ Grade ____ Home Ph # _____

MEDICATION _____ Emergency Ph # _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Urbana School District #116 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self administer, while under the supervision of the employees and agents of the School District), lawfully prescribed prescription and non-prescription medication in the manner prescribed by our physician/healthcare provider. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. *I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication administration.*

Parent Signature: _____ Date: _____

<u>*TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider*</u>

Medication_____ Dosage _____

Time to be administered _____ Side Effects _____

Effective Date: From: _____ To: _____

Additional Notes:_____

I hereby confirm the schedule for medication administration described above makes it impossible to provide the required dose outside of school hours.

_____ _____ _____

Printed Name of Physician/Healthcare Provider Signature Date

_____ _____ _____

Physician/Healthcare Providers address Phone Number Fax Number

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED CONTAINERS & FOLLOW AGE RECOMMENDATIONS

Urbana School District #116
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The School District will limit its dispensation of medication to cases where failure to take prescribed medication could jeopardize the students' health and/or education and where it is not possible for a parent to administer the medication and the medication cannot be prescribed in doses scheduled for before and after school hours. *Parent help and consideration is essential for the safety of children who must receive medication while at school.*

1. All medications, including non-prescription drugs, given at school shall be prescribed by a physician. A School Medication Authorization Form must be carefully completed each school year. The physician MUST sign the form and a parent/guardian MUST sign the form.

2. A SEPARATE form is required for each medication.

3. Students are not allowed to carry any medication on their person. EXCEPTIONS will be made for students requiring Asthma medication and/or Epinephrine Auto-Injector providing the appropriate documentation from the physician and parent/guardian is completed and received by the school district.

4. Any change in medication dosage or administration MUST have written authorization from the prescriber.

5. Prescription medication MUST be sent in the original container with: students name, name of medication, dosage, schedule of administration, expiration date, prescribers name.

6. Non-Prescription medication MUST be sent in the original container and MUST be age appropriate for the student taking them. A Medication Authorization Form MUST be completed for non-prescription medications.

7. **NO MEDICATIONS WILL BE GIVEN AT SCHOOL UNLESS THE ABOVE GUIDELINES ARE MET**

8. All prescription and non prescription medications MUST be taken to the school office by the parent/guardian where it will be kept in a locked space. EXCEPTIONS will be made for Asthma medication and/or Epinephrine Auto-Injectors (see #3 above).

9. **Please talk with your physician about scheduling medications to avoid school hours whenever possible. Prescription medications which are to be taken 3 times a day normally do not need to be given at school.*

10. It is the parent/guardian's responsibility to pick up all unused medications before the last day of school. Any medication left at school will be disposed of properly by the nurse. We cannot send medication home with students (unless it is an authorized Self-Carry medication).

11. *Please take into consideration if your child will be attending a summer school program and may still need medication while at school, in which case the medication can be left at school at the end of the school year. Please work with your Building Nurse on how the medication will be administered during the summer school program.*

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To be completed by Parent/Guardian:

Students Name _____ Birth Date _____

Address _____ School _____

Teacher _____ Grade ____ Home Ph # _____

MEDICATION _____ Emergency Ph # _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Urbana School District #116 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self administer, while under the supervision of the employees and agents of the School District), lawfully prescribed prescription and non-prescription medication in the manner prescribed by our physician/healthcare provider. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. *I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication administration.*

Parent Signature: _____ Date: _____

TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider

Medication_____ Dosage _____

Time to be administered _____ Side Effects _____

Effective Date: From: _____ To: _____

Additional Notes:_____

I hereby confirm the schedule for medication administration described above makes it impossible to provide the required dose outside of school hours.

_____ _____ _____

Printed Name of Physician/Healthcare Provider Signature Date

_____ _____ _____

Physician/Healthcare Providers address Phone Number Fax Number

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED CONTAINERS & FOLLOW AGE RECOMMENDATIONS

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The School District will limit its dispensation of medication to cases where failure to take prescribed medication could jeopardize the students' health and/or education and where it is not possible for a parent to administer the medication and the medication cannot be prescribed in doses scheduled for before and after school hours. *Parent help and consideration is essential for the safety of children who must receive medication while at school.*

1. All medications, including non-prescription drugs, given at school shall be prescribed by a physician. A School Medication Authorization Form must be carefully completed each school year. The physician MUST sign the form and a parent/guardian MUST sign the form.

2. A SEPARATE form is required for each medication.

3. Students are not allowed to carry any medication on their person. EXCEPTIONS will be made for students requiring Asthma medication and/or Epinephrine Auto-Injector providing the appropriate documentation from the physician and parent/guardian is completed and received by the school district.

4. Any change in medication dosage or administration MUST have written authorization from the prescriber.

5. Prescription medication MUST be sent in the original container with: students name, name of medication, dosage, schedule of administration, expiration date, prescribers name.

6. Non-Prescription medication MUST be sent in the original container and MUST be age appropriate for the student taking them. A Medication Authorization Form MUST be completed for non-prescription medications.

7. **NO MEDICATIONS WILL BE GIVEN AT SCHOOL UNLESS THE ABOVE GUIDELINES ARE MET**

8. All prescription and non prescription medications MUST be taken to the school office by the parent/guardian where it will be kept in a locked space. EXCEPTIONS will be made for Asthma medication and/or Epinephrine Auto-Injectors (see #3 above).

9. **Please talk with your physician about scheduling medications to avoid school hours whenever possible. Prescription medications which are to be taken 3 times a day normally do not need to be given at school.*

10. It is the parent/guardian's responsibility to pick up all unused medications before the last day of school. Any medication left at school will be disposed of properly by the nurse. We cannot send medication home with students (unless it is an authorized Self-Carry medication).

11. *Please take into consideration if your child will be attending a summer school program and may still need medication while at school, in which case the medication can be left at school at the end of the school year. Please work with your Building Nurse on how the medication will be administered during the summer school program.*

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Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize: _____
_____
_____

to disclose protected health information and/or educational records to:

_____
_____
_____

_____ Check here if authorization is given for the parties listed above to mutually exchange the information described below.

Description:

The health information to be disclosed consists of (check all that apply):

_____ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records. (Cross out any item that you do not authorize to be released)
_____ Records regarding treatment for the following condition or injury _____
_____ Records covering the period of time between _____ and _____
_____ Other (be specific, including dates) _____

The education information to be disclosed consists of (check all that apply):

_____ Any and all educational records, including special education records
_____ Records covering the period of time between _____ and _____
_____ Other _____

Purpose: This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

_____ Educational evaluation and program planning
_____ Health assessment and planning for health care services and treatment in school
_____ Medical evaluation and treatment
_____ Other _____

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature _____ Date _____

Student Signature* _____ Date _____

*student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records

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***SELF-ADMINISTRATION* OF ASTHMA MEDICATION AUTHORIZATION FORM**

To be completed by Parent/Guardian:

Students Name _____ Birth Date _____

Address _____ School _____

Teacher _____ Grade ____ Home Ph # _____

MEDICATION _____ Emergency Ph # _____

As the parent or guardian of the above named student I acknowledge that Urbana School Dist.116 and its employees and agents are to incur no liability except for willful and wanton conduct as a result of any injury arising from the self-administration or carrying of asthma medication, by my child regardless of whether authorization was given by me, as the Parent/Guardian or by my child's physician, physician assistant, or advanced practice registered nurse. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration or carrying of asthma medication by my child regardless of whether authorization was given by me, as the Parent/Guardian or by my child's physician, physician assistant, or advanced practice registered nurse.

Parent Signature: _____ Date: _____

PLEASE NOTE: For a reliever/rescue inhaler the Parent/Guardian may choose to provide the school with a current prescription label instead of a written doctor's order. The label must contain the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered.

I CHOOSE TO SUBMIT A PRESCRIPTION LABEL: _____ Yes _____ No
(If you have chosen **NOT** to submit the prescription label, your child's healthcare provider must complete the area below)

****

TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider

Medication_____ Dosage _____

Time to be administered _____ Side Effects _____

Effective Date: From: _____ To: _____

As the ***Physician/Healthcare Provider*** for the above named student, I certify that he/she has been instructed in the use and self-administration of the above named medication and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

_____ _____ _____

Printed Name of Physician/Healthcare Provider Signature Date

_____ _____ _____

Physician/Healthcare Providers address Phone Number Fax Number

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USD116 SELF-ADMINISTRATION OF ASTHMA MEDICATION GUIDELINES

The parent/guardian may request that their child be permitted to self-administer and carry their asthma medication as long as certain conditions are met. Parent help and consideration is essential in providing for the safety of all students attending school.

1) The medication must pertain to your child's asthma and be prescribed by a physician, physician assistant, or advanced practice registered nurse.

2) A school self-administration of asthma medication authorization form must be signed by the parent/guardian.

3) If you are requesting that your child be allowed to carry and self administer their reliever/rescue inhaler, a current prescription label may be submitted instead of a written order from your child's healthcare provider. The prescription label must be current and contain the following information; name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered. (Asthma medication must be in the correctly labeled prescription container).

4) Parents are responsible for notifying the school of any changes in the medication, or in their child's condition.

5) It is recommended that you keep an additional dose of the asthma medication at school in case your child has misplaced or forgotten their medication.

6) The permission for self-administration of asthma medication is effective for **ONLY** the school year during which it is granted.

7) A student may possess his/her asthma medication while in school, at a school sponsored activity, while under the supervision of school personnel or before or after school care on school operated property.

8) You are responsible for reminding your child to make sure they have their asthma medication while attending any before or after school activities, and when leaving the school campus for any reason, including field trips.

Please contact the the Building Nurse or the District Nurse Ph # 384-3549 if you have any questions.

Sincerely, Amy Marx RN | District Nurse