CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Diana Taylor RN BSN
Campbell County Health Services Coordinator
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Dear Parent/Guardian

In preparation for the upcoming school year, it is important that we have accurate information/authorization to the special health-care needs of your child in the school setting.

Please have your child's physician complete the information on the appropriate forms prior to the beginning of the new school year. This information will be used to develop an Individualized Health Care Plan for your child in the school setting. Medications/procedures will not be administered until all forms are properly completed/signed by the parent and physician, and the parent/guardian provides medications and all supplies required.

All packets and medication forms are available on the Campbell County web page on the Health Services tab under "Departments". If your child has diabetes, Children's Hospital provides a school packet containing all information required for school attendance for those students managed through their clinic. Please contact them now and request that the packet be completed.

After July 25, please contact the nurse of the school your child will attend to set a time to meet with appropriate staff. If you have further questions, please contact me at: 859-635-2173, ext: 1008.

Thank you in advance for your cooperation. With your assistance we can insure a smooth transition for your child into the new school year.

Sincerely,

Diana Taylor RN

Campbell County Schools Health Services

ASTHMA: Individualized Health Care Plan (IHP)
SCHOOL YEAR _____

Student Name: _____ **DOB:** _____ **Grade**: _____
School: _____ **Bus# A.M.**_____ **Bus# PM** _____
Teacher: _____

Emergency Contact Information:
Parent/Guardian: _____ Work Phone: _____ Home: _____
Parent/Guardian: _____ Work Phone: _____ Home: _____
Emergency Contact: _____ Phone: _____

****Parent/Guardian is responsible for all supplies, medication****

Triggers that may bring on an asthma episode (check all that apply):

___Exercise	____ Cigarette smoke	____Odors/fumes
___Emotional stress	____ Dust	____ Pollens
___Respiratory infections	____ Exposure to cold/hot air	____ Molds

___Animals/insects _____
___Food(s) _____
___Other _____

Frequency of asthma attacks: _____

Number hospitalizations related to asthma attacks in past year: _____

List any environmental **measures**, pre-medications or dietary restrictions needed to **prevent** an **asthma episode**: _____

Current Asthma-Related Medications:
1) Medication: _____ Dosage: _____ Time(s): _____
2) Medication: _____ Dosage: _____ Time(s): _____
3) Medication: _____ Dosage: _____ Time(s): _____

Allergies: _____

Signs/Symptoms that may occur during an asthma episode (check all that apply):

___ Tightness in chest	___ Fear/anxiety	___Wheezing
___ Shortness of breath	___ Nasal Flaring	___ Fatigue
___ Agitation	___ Increased respiratory rate	___ Coughing
___ Inability to speak without taking a breath		___ Itchy chin

___ Other: _____

Will student have an inhaler at school: ___ Yes ___NO Self Carry: ____Yes ____No Location:

Does student use a **peak flow meter**? Yes ___ No ___ **Best peak flow**: _____
Student's Limitations or Special Considerations: _____
_____

Campbell County Schools Health Services
Asthma IHP (Cont.)

Student Name: _____

Action Plan for Asthma Episode

Steps to be taken in management of Asthma Episode (YELLOW ZONE)

___ Talk calmly to the student
___ Help the student sit in a comfortable position. Student may lean forward to assist breathing
___ Encourage deep, slow breathing
___ Notify school nurse or trained personnel
___ Administer medication(s) ordered in response to asthma episode
___ Obtain Peak Flow reading (if applicable)
___ Notify parent/guardian
___ Monitor and record vital signs until improvement
___ Monitor and record lung sounds until improvement
___ Assist student in administration of prescribed medication(s)
___ Other actions include: _____

Medication(s) ordered per physician to be **administered** in the event of an **asthma episode**:

1) Medication: _____ Dose: _____ Route: _____
*Indications for use: _____ Self-Carry: yes no
2) Medication: _____ Dose: _____ Route: _____
*Indications for use: _____

Seek Emergency Medical Help, call 911 (RED ZONE)

___ Student shows no improvement ____ minutes after medication administered
___ Has a peak flow reading of _____
___ Blue or grey discoloration of the lips and/or nail beds
___ Student has difficulties in walking or talking (cannot speak in complete sentences)
___ Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to Breathe
___ Other: _____

Special Instructions/Considerations:

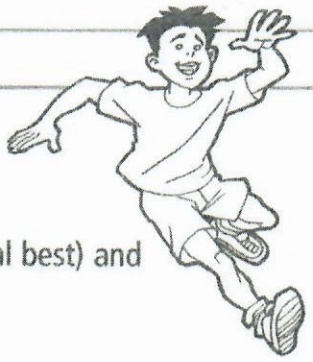
_____
_____

As parent of the above-named student, I realize I am responsible for keeping the school nurse updated regarding any changes to my child's health status, care, and medication order. I realize I am responsible for all supplies & equipment needed. I also realize the nurse will share this information with appropriate school staff on a need-to-know basis.

Parent Signature _____ Date_____
Physician Signature _____ Date_____
School Nurse Signature _____ Date_____

Using Symptoms and/or Peak Flow to Know Your Zone

Green Zone



- ✔ No cough or wheeze at day or night.
- ✔ No chest tightness.

OR

- ✔ **Peak flow** is between_____ (80% of personal best) and _____ (100% of personal best).

Yellow Zone - Caution!

Any asthma symptoms:

- ✔ Cough or wheeze at day or night.
- ✔ Chest tightness.
- ✔ Problems playing.
- ✔ Waking at night with asthma symptoms.

OR

- ✔ **Peak flow** is between_____ (50% of personal best) and _____(80% of personal best).

Red Zone - Medical Alert!

Any asthma symptoms:

- ✔ Persistent cough or wheeze.
- ✔ Severe chest tightness.
- ✔ Can not walk, talk, or move well.
- ✔ Blue skin color around lips or nails.

OR

- ✔ **Peak flow is below**_____ (50% of personal best).

10-13-04

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Consent for Administration of Medication at School

Student Name: _____ Grade: ____ Teacher: _____

School: _____

Name of Medication: _____

Dosage: _____ Time(s) of administration: _____ _____ _____

As Needed (PRN): Indicators for use: _____

Route of Administration: _____

Diagnosis or Reason for Medication to be Administered: _____

Possible Side-Effects: _____

Student Allergies: _____

Physician Authorization

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Guardian Authorization

I authorize an employee of the school to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage/times of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.
I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and expiration date of medication.
I waiver any liability on behalf of the school as a result of administration of the above medication.

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Phone: _____

Contact #2 Name: _____ Phone: _____

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Authorization to Carry/Self-Administer Medication

Pursuant to the laws of the Commonwealth of Kentucky and Campbell County Schools Board Policy, students may be Granted permission to carry and self-administer medication for use as needed during school hours and during school sponsored activities. This is limited to medication for treatment of asthma, severe allergic reaction, or diabetes. The student must have training in the proper use and administration of the medication named and be responsible for safe use.

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Condition for which Medication is Prescribed: _____

Medication Name: _____ Dosage: _____ Route of Administration: _____

Time/Frequency of Administration: _____ If PRN (as needed) frequency: _____

If PRN (as needed), for what observable signs/symptoms: _____

Possible/Relevant Side Effects: _____

Additional Instructions/Follow Up: _____

****This student has been instructed on self-administration & shows capability to carry and self-administer this medication. He is authorized to do so in school****

Physician Signature: _____ Printed Name: _____
Phone Number: _____ Date: _____

Parent/Guardian Authorization

I request that my child be permitted to carry and self-administer the medication ordered above. I understand the medication must be in its original prescription container. I accept responsibility for this permission and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school and its employees/agents, harmless against any claims relating to the self-administration of such medication.

Parent Signature: _____ Date: _____

AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned parent/guardian does hereby consent to the intervention of the volunteer staff member in accordance with the instructions contained in the attached letter from the child's physician. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

Dated at Alexandria, Kentucky, this the _____ day of _____, _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)