MEDICATION ORDER TO CARRY ASTHMA INHALER

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY ASTHMA INHALER

For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

These requests are exceptions to School Board policy JLCD and must be approved.

1. ***Parents will submit the following forms:***
   - ***a.*** ***Request for Approval for Students to Carry Prescribed Medication*** *(completed by parent)*
   - ***b.*** ***Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook (Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)***
   - ***c.*** ***Medication Release of Liability form***
   - ***d.*** ***Completed Asthma Action Plan and Authorization for Medication form*** *(completed by medical provider)*

   All forms must be in order and signed.

2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

3. *The school nurse will complete an Emergency Care Health Plan as appropriate.*

4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*

5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*

6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

8. *The school's registered nurse and principal will sign approving the request.*

9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

R-04/25

NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

REQUEST FOR APPROVAL FOR STUDENT TO CARRY ASTHMA INHALER

(<u>This form is to be completed by the parent</u>. The medical provider must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)
For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

Name of Student: _____ Birth date: _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

_____

Additional information: _____

I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. ***A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it.*** *I understand this request is for the current school year only.*

_____ _____
Parent's Signature *Date*

Attached and completed: (All must be reviewed by RN)
___ *Signed order from Medical Provider that student is trained and able to carry*
___ *Parent signature to request*
___ *Exception to Categories BSC and BESO (parent and student signed)*
___ *Medical Release of Liability*

Notes:_____
_____
_____

Approved for current school year:
_____*, RN* _____
School Nurse *Date*

_____ _____
Principal *Date*

R- 04/25

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RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)

(Request to Carry Prescribed Medication on One's Person)

I request my son/daughter _____carry the following prescribed medication: _____.

I have read Category BSC and Category BESO which state:

> ***Category BSC****: Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*
>
> ***Category BESO****: Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from to school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed_____ (Parent) Date: _____

Signed_____ (Student) Date: _____

R-04/25

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MEDICATION RELEASE OF LIABILITY FORM

Student: _____ School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone: #_____
(Home)

_____ Phone: #_____
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of_____

I hereby request and authorize you to assist and/or give

_____
(Dose and Medication)

to: _____, as prescribed by
(Student's Name)

_____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

_____

_____

_____ _____
Parent/Guardian Signature Date

R-04/25

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

EMERGENCY CONTACT

NAME PHONE

RELATIONSHIP

Additional info:

GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

Maintenance/Controller ☐ **None** ☐ **Daily**

Day Puffs **Night Puffs**

☐ puffs ☐ puffs

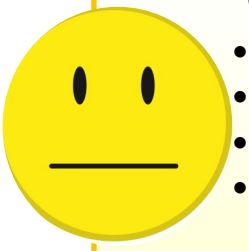
☐ puffs ☐ puffs

☐ Montelukast/Singulair ☐ Mg once daily

Use controller daily, even when I feel fine. *Spacer recommended with HFA inhalers.*

For Asthma with exercise add: ☐ **puffs, or** ☐ **puffs**

15 minutes prior to exercise: ☐ **routinely** ☐ **only if needed**



YELLOW ZONE: Caution!

- Cough
- Wheeze
- Chest tightness
- Shortness of breath

Add: quick-relief medicine—to your GREEN ZONE medicines.

SMART

If your quick reliever medicine is: ☐ **budesonide/formoterol** ☐ **mometasone/formoterol**

Take: 1 puff every 10 minutes if needed x 3 until symptoms resolve and return to green zone.

If symptoms continue add: ☐ **1 puff as needed up to max of 8 puffs/day for ages 4-11**

☐ **1 puff as needed up to max 12 puffs/day for ages 12+**

☐ ☐

☐ Call your Provider if you need continued maximum quick relief medicine or medicine is not working.

Other

If your quick reliever medicine is: **albuterol**

Take: ☐ puffs or 1 nebulizer tx. Can repeat every 15 minutes up to maximum of 3 doses in 1 hour.

If symptoms resolve, return to GREEN ZONE and continue monitoring.

If symptoms continue after 1 hour then continue controller and

Add: ☐ puffs every 4-6 hours as needed until symptoms resolve

☐ Continue every 4-6 hours for ☐ days

☐ ☐

RED ZONE:DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show

If you have any of these danger signs:

Dial 911 now/ GO TO THE EMERGENCY DEPARTMENT!

- Take 1 puff of budesonide/formoterol or mometasone/formoterol. Wait 1-3 minutes. If there is no improvement, take additional puff(s) up to a maximum of 6 puffs **in route to emergency department.**
- If only albuterol is available, take ☐ puffs or nebulizer as often as need ed until help arrives or **in route to emergency department.**

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: ☐ in clinic or ☐ with student (self-carry)

PARENT/Guardian Signature:_____ Date:_____

School nurse/Staff Signature:_____ Date:_____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

☐ Student has demonstrated the ability to safely and effectively self-carry and self- administer inhaled asthma medication.

☐ Student needs assistance & should not self–carry.

_____Date_____

MD/DO/NP/PA signature

Approved June 2023 Virginia Asthma Action Plan Expert Group convened by the Consortium for infant and Child Health at Eastern Virginia Medical School. *Updated February 2025*