OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
INHALER AUTHORIZATION

CSO/15-H3A

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART 1 TO BE COMPLETED BY PARENT

I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Inhaler □ Renewal □ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date_____ Time_____

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances.

_____ Parent or Guardian Signature

_____ Daytime Telephone

_____ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)

DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS	MEDICATION AND ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL	INTERVAL FOR REPEATING DOSAGE:
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which inhalers are to be taken

Check ✓ the appropriate boxes:

□ I believe that this student has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

□ The student is to carry an inhaler during school and during sanctioned events with principal approval. (An additional inhaler, to be used as backup, WILL BE kept in the clinic or other approved school location.)

□ It is not necessary for the student to carry his inhaler during school, the inhaler will be kept in the clinic or other approved school location.

□ Asthma Action Plan is attached

_____ Licensed Health Care Provider (Print)

_____ Licensed Health Care Provider (Signature)

_____ Telephone or Fax

_____ Date

_____ Parent or Guardian

_____ Parent or Guardian Signature

_____ Telephone

_____ Date

_____ Student Signature (Required if student carries inhaler)

_____ Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

□ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

□ Inhaler is appropriately labeled.

_____ Date by which any unused inhaler is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

□ I have reviewed the proper use of the inhaler with the student and agree/disagree that student should self carry in school.

_____ Signature

_____ Date

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here.**
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, EpiPen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be prescribed by a doctor or dentist and must be in the original, small, sealed container with a current pharmacy prescription label. **Medication sent in baggies or unlabeled containers will not be given.**
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, EpiPen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

I hereby request that the medication specified above be given to the above named student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Charleston, its servants, agents, and employees, including, but not limited to the parish, school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Charleston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Signature of Parent/Guardian:_____ Date:_____

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
ASTHMA ACTION PLAN

CSO/15-H3

PROCEDURES ON REVERSE

PART I TO BE COMPLETED BY PARENT:

Student _____ **DOB** _____ **School** _____ **Grade** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

What triggers your child's asthma attack: (Check all that apply)

☐ Illness ☐ Cigarette or other smoke ☐ Food _____
☐ Emotions ☐ Exercise ☐ Allergies ☐ cat ☐ dog ☐ dust ☐ mold ☐ pollen
☐ Weather changes ☐ Chemical odors ☐ Other
_____

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

☐ Cough ☐ "Tightness" in chest ☐ Rubbing chin/neck
☐ Shortness of breath ☐ Breathing hard/fast ☐ Feeling tired/weak
☐ Wheezing ☐ Runny nose ☐ Other _____

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER:

The child's asthma is: ☐ mild persistent ☐ moderate persistent ☐ severe persistent ☐ EXERCISE-INDUCED

Symptoms	Peak Flow	Treatment (*For medication administered during school sanctioned activities, complete appropriate Inhaler/ Medication Authorization form)*		
• No cough or wheeze • Able to sleep through the night • Able to run and play • Usual medications control asthma	**GREEN ZONE** **WELL** > _____	**Controller**	**How much**	**When**
		☐ Advair		
		☐ Flovent (with spacer)		
		☐ Pulmicort		
		☐ Singulair		
		☐ Serevent		
		☐ Other		
		Relievers		
		☐ Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart prn	☐ 20 min before exercise
		☐ Other		
• Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities • Needs reliever medications more often	**YELLOW ZONE** **SICK** _____ to _____	**1.** Continue daily controller medications **2.** Give albuterol 2-4 puffs (one minute between puffs) with spacer or 1 nebulizer treatment, wait 20 min. ☐ If no improvement, repeat 2-4 puffs. Wait 20 minutes. ☐ If no improvement, repeat 2-4 puffs. This will be 3 doses in one hour, proceed to 3 **3.** If child returns to Green Zone: ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ Increase controller to _____ for next 7 days **4.** ☐ No physical exercise ☐ Physical exercise as tolerated **If child remains in Yellow Zone for more than 1-2 days or requires albuterol more than every 4 hours, call your doctor NOW!**		
• Very short of breath, difficulty breathing • Constant cough • Reliever medications do not help	**RED ZONE** **EMERGENCY!** < _____	**Give albuterol (2 puffs with spacer) NOW, and repeat every 20 minutes for 2 more doses OR give 1 dose nebulized albuterol – Call your doctor** **Seek emergency care or call 911 if:** ☐ Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol ☐ Trouble talking or walking ☐ Lips or fingernails are gray or blue ☐ Chest or neck is pulling in with breathing		

For inhaled medications:

☐ Student is able to perform procedure alone and may carry the inhaler with them, consult school nurse for local protocol
☐ Student is able to perform procedure with supervision
☐ Student requires a staff member to perform procedure

Notify health care provider if:

☐ More than 2 absences related to asthma per month
☐ Albuterol is being used as a rescue medication 2 times per week at school
☐ The child is persistently in the Yellow Zone

_____ Licensed Health Care Provider Signature
_____ Date
_____ Phone
☐ Current school year

I approve this Asthma Action Plan for my child. I give my permission for school personnel to follow this plan, release the information contained in this management plan to all adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

Parent Signature _____ Date _____

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
ASTHMA ACTION PLAN
PAGE 2

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Student _____ **School** _____ **Teacher/Grade** _____

Parent/Caregiver _____ **Phone (H)** _____ **Phone (W)** _____ **Phone (Cell)** _____

Physician _____ **Office phone number** _____

ASTHMA ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- Asthma Action Plan Part I and II, complete **yes** **no**
- Medication authorization complete **yes** **no** **n/a**
- Inhaler authorization complete **yes** **no** **n/a**
- Medication maintained in school designated area **yes** **no**
- Medication self carried **yes** **no**
- Expiration date of medication (s) _____ _____
- Staff trained in medication administration **yes** **no**
- Copies of plan provided to: Educational **yes** **no** **n/a** After school **yes** **no** **n/a**
  Athletic **yes** **no** **n/a** Food service **yes** **no** **n/a**

IMMEDIATE ACTION FOR SYMPTOMS

IF YOU SEE THIS:	**DO THIS:**
Complains of chest tightness Coughing Difficulty breathing Wheezing	1. Stop activity 2. Give one puff of rescue inhaler 3. Wait at least 1 minute 4. Give second puff of rescue inhaler 5. Allow student to rest 6. If no improvement in 15 minutes, repeat steps 2-4 7. If symptoms worsen call 911 and parents/emergency contact
IF YOU SEE THIS	**DO THIS IMMEDIATELY**
Coughs constantly Struggles or gasps for breath Chest and neck pull in with breathing Stooped over posture Trouble walking or talking Lips or fingernails are gray or blue	1. Call 911 2. Give rescue medication 3. Call parents/emergency contact

Full Asthma Action Plan has been implemented.

_____ _____
Principal or Registered Nurse Date