School Year: _____

Lexington-Fayette County Health Department

School Health
650 Newtown Pike
Lexington, KY 40508-1197
(859) 288-2314
(859) 288-2313 Fax

ASTHMA PARENT PACKET

Dear Parent/Guardian:

Please fill out the attached asthma information and return it to your School Nurse. It will be shared with appropriate persons such as your student's classroom teacher and physical education teacher. Your comments and instructions will help us to assist your student during asthma episodes as well as to minimize restrictions.

According to Fayette County Public Schools' Medication Policy, **ALL** medications, including inhalers, are to be stored in a secure location and students are to be supervised by school staff when taking them. The purpose of this policy is to assure safe use of all medication, to prevent errors, and to prevent children from sharing their medications with others. The school staff is required by policy to be responsible for safe and supervised medication administration to students, except as noted below.

Students are allowed to carry their inhalers if the following conditions are met:

- **It has been determined that student is socially, cognitively, physically, and emotionally mature enough to carry and administer the inhaler.**
- **Parent and Physician Authorization Forms are completed and on file at school.**

When students self-administer medication the school staff will NOT be responsible for monitoring frequency of use, expiration date, or amount of medication available for use.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency phone numbers.

The following need to be returned to the School Nurse at your school:

- **Asthma Healthcare Plan**
- **Medication Authorization Form**

We are looking forward to a great year with your student!

Please call the School Health Services Program at 288-2314 if you have any questions.

ASTHMA HEALTHCARE PLAN

School Year: _____

MEDICAL CONCERN: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____ **DOB:** ___ / ___ / ___

Allergies: _____

School: _____ Teacher: _____ Grade: ____

Bus Rider: ☐ Yes ☐ No Bus #: AM _____ PM _____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Doctor: _____Phone #: _____ Hospital of Choice: _____

Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Or call Emergency Contact if unable to reach Parent/Guardian:

Name: _____ *Phone:* _____ *Relation:* _____

****

1. Date of student's last asthma episode? ___ / ___ / ___
2. Has student ever been hospitalized for asthma? Yes ☐ No ☐
3. What triggers your student's asthma episodes? (Check all boxes that apply)

   ☐ Pollen ☐ Mold ☐ Dust ☐ Feathers ☐ Animal Dander ☐ Perfume ☐ Air Pollution

   ☐ Smoke ☐ Respiratory Infections ☐ Cold Air ☐ Weather Changes ☐ Vigorous Exercise

   ☐ Foods (Specify) _____

   Other (Specify) _____
4. What are your student's asthma symptoms? (Check all boxes that apply)

   ☐ Coughing ☐ Wheezing ☐ Chest Tightness ☐ Anxiety/Restlessness

   ☐ Difficulty Breathing/Shortness of Breath ☐ Other (Specify) _____
5. List the Medication(s) your student takes for asthma:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

6. List any other Medication(s) your student takes:

Name of Medication:	Dosage:	Time of Day:
_____	_____	_____
_____	_____	_____

7. Location of Medication/Inhaler: _____
8. Additional Comments: _____

   _____

Reviewed by: _____ *RN* *Date:* _____

MEDICATION AUTHORIZATION FORM

(Please complete one form for each of your student's medications.)

Student's Name: _____ **DOB:** _____

Allergies: _____

Medication: _____ **Dosage:** _____

Reason for medication or diagnosis: _____

School: _____ **School Year:** _____

In order for school personnel to administer any type of medication to the student, the Parent/Guardian must provide this signed authorization form. Medicine will be dispensed to the student by the School Nurse or by unlicensed school personnel trained and deemed competent by the School Nurse. The medicine must be sent to the school with complete instructions and in the original container with the Physician's Order **OR** pharmacy label firmly attached to the medication.

Please be sure to complete ALL of the information on this authorization form before returning it to school.

ANY OVER THE COUNTER MEDICATIONS MUST BE ACCOMPANIED BY A PHYSICIAN'S ORDER

Medication to be administered during the school day must be brought to the school by the Parent/Guardian. Parents/Guardians shall pick up unused medication within two (2) weeks of the last day of school or it shall be destroyed. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

The first dose of any new medication should NOT be given at school.

****

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent/Guardian of the student named above, request that a* ****trained staff member administer*** *the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or the medication will be destroyed.*

**** Parent / Student are responsible to have medication available at school.***

X _____ ____ / ____ / ____
(Parent/Guardian's Signature) Date

Home Phone: _____ Work: _____ Cell: _____

****

Reviewed by: _____ *RN Date:* _____