Boone County Schools
School Health Services Department

# Asthma Health Care Plan

Plan Date: _____

**Student Name**: _____ **Date of Birth**: _____ **Grade**: _____

| Asthma Triggers | Asthma Symptoms |
|---|---|
| ☐ Respiratory infection | ☐ Wheezing |
| ☐ Exercise | ☐ Coughing |
| ☐ Allergic reaction | ☐ Shortness of breath |
| ☐ Exposure to cold or humid air | ☐ Unable to speak without taking a breath |
| ☐ Odors | ☐ Bluish color of skin/nails |
| ☐ Other _____ | ☐ Other _____ |

How often do asthma attacks occur? _____

Has the student been hospitalized in the last year? ☐ NO ☐ YES

Is a peak flow meter used? ☐ NO ☐ YES, best flow rate is? _____

Are medications needed to control Asthma? ☐ NO ☐ YES, please list medications below.

| Medications | Dose |
|---|---|
| | |
| | |
| | |

**Basic Asthma First Aid**

- Allow student to use asthma medication (offer assistance if needed)
- Encourage student to relax. (e.g. slow, deep breathing)
- Stay with student to monitor symptoms
  - If symptoms decrease after 15 minutes, student may return to class.
  - If symptoms remain the same after 15 minutes, contact parent.
  - If symptoms increase, 911 will be called and CPR began if necessary.

**Special considerations, precautions, instructions:**

_____

_____

**Parent Name:** _____ **Phone Number:** _____

**Parent Signature:** _____ **Date:** _____

**School Nurse Use Only**

| | | |
|---|---|---|
| _____ Stable | _____ No ongoing management | Review Date: _____ |
| _____ Potential complications, Hypoxia | _____ Standard asthma procedure | |
| _____ High risk for ineffective breathing | _____ Standard school medication | |
| | _____ Individual HCP | Nurse Signature: _____ |
| _____ Delegated or assigned caregiver name and date trained _____ | | |

*Revised: Nov. 2018 SLW*

Boone County Schools
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# Medication Administration Consent Form

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

**Student's Name:** _____ **Date of Birth:** _____ **Grade:** _____

**Allergies:** _____

****Please advise the school nurse immediately of any changes in medication or dosing.****

**Medication 1:** _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

***For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:**

| **Physician's initial in appropriate box** | |
|---|---|
| ☐ may CARRY | ☐ may SELF-ADMINISTER |

**Medication 2:** _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

***For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:**

| **Physician's initial in appropriate box** | |
|---|---|
| ☐ may CARRY | ☐ may SELF-ADMINISTER |

**Specific to field trips:** In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on a field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

**Trained Unlicensed School Personnel:** The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administrating the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency where in immediate intervention is required.

**Parent/ Guardian signature:** _____ **Date:** _____

**Physician signature:** _____ **Date:** _____

**Physician name:** _____ **Phone number:** _____

**Staff administering medication are trained annually by a registered nurse.**

*Revised: Nov. 2018 SLW*

| Student's Emergency Medication Location | |
|---|---|
| ☐ First Aid Room | ☐ Self-carries; Location: _____ |

**Boone County Schools**
**Student Services Division**
**School Health Services Department**
**Transportation/Student Health Concerns**

**Photo**

**School Year**: _____

**Student Name:** _____

**Address:** _____

**Bus Number:** _____ **School:** _____

**Date of Birth:** _____ **Age:** _____ **Grade:** _____

**Health concern of student:** _____

Medication/supplies which will be with student during bus transportation: _____

_____

Is student responsible for medication administration? Yes ☐ No ☐

Emergency care to be given to student by bus driver: _____

_____

Comments: _____

Parent /Guardian signature: _____

Daytime phone number: _____ Date: _____

**This completed form must be returned to your child's school office in order for transportation to be notified.**

***School nurse is to scan completed form to Transportation: cynthia.buttery@boone.kyschools.us***

*Revised: Sep. 2019 SLW*