Brainerd Public Schools
Opportunity. Innovation. Success.

Dear Parent/Guardian,

The staff at ISD 181 want to promote a positive and healthy learning environment for every student. Our records indicate that your student has a history of asthma. In an effort for a smooth transition into the new school year, we are sending this information packet for you and your student's physician to **complete and return by the start of the new school year.**

Please help us care for your student by completing and returning all the enclosed forms.

1. Asthma Action Plan - This NEEDS to be signed by you and your student's physician.

2. Prescription Medication Administration Form (white) - NEEDS to be signed by you and your student's physician.

or

3. Self-Administration/Carry Prescription Form (blue) - NEEDS to be signed by your and your student's physician. Physicians must also include a written order indicating the student is able to self carry/administer their inhalers.
    a. Your District Nurses have asked the building nurses to also verify with students appropriate use of their inhaler.

If your student no longer has asthma symptoms, or it is well controlled and no longer requires an Action Plan, please return this form indicating that so we can update your student's school health record. Thank you for your time in assisting us to promote health and safety for your student.

We are looking forward to a great school year!

Kim Hughes, RN
District Nurse - PreK - 4th Grade
(218) 454-5408

Jena Litke, RN, LSN
District Nurse - Secondary and Alternative
(218) 454-6247

District Health Services
702 S. 5th Street
Brainerd, MN 56401
218-454-6945 FAX: 218-454-6325

**BRAINERD PUBLIC SCHOOLS**
**District Health Office**
**Brainerd, Minnesota**
**(218) 454-6945 Fax (218) 454-6325**

**School Year _____/_____**

# PRESCRIPTION MEDICATION

## PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

**(TO BE RENEWED ANNUALLY)**

Last Name: _____First Name:_____ Date of Birth: _____

Parent(s) /Guardian(s): _____

School: _____ Teacher/Grade: _____ Weight: _____

## PHYSICIAN'S ORDER

I hereby request and authorize you to administer to the above named student:

| | MEDICATION | DOSAGE | TIME | DURATION |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Diagnosis/reason for medication: _____ ICD Code:_____

Other medications this student is taking: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (PRINTED) Physician's Phone #

Clinic: _____ Fax #: _____

## PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's physician.

2. I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.

3. I give permission for the school nurse to communicate with other school personnel about the action and side effects of the medication.

4. I give permission for the school nurse to consult with this child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.

5. Field Trips – I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

6. I release all school personnel, ISD #181, and any responsible adult administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

_____ Phone #: _____ Date: _____
Parent(s)/Guardian(s) Signature Phone #: _____

**BRAINERD PUBLIC SCHOOLS**
**District Health Office**
**Brainerd, Minnesota**

# ADMINISTERING MEDICATION IN SCHOOL

Medications required to be administered to a student during the school day must be brought to school by the parent or guardian and left with the building nurse.

Before any medication will be administered, a **Prescription Medication: Physician Order and Parent Authorization** form or a **Self-Administration of Medication: Physician Order and Parent Authorization** form which has been signed by the physician and parent or guardian of the student must be on file with the designated school representative. This authorization must include all of the following: The name of the student, name of the medication, dosage to be given, the time or frequency that the medication is to be given, a diagnosis or reason the medication is needed, and a signature from the physician and parent or guardian.

The **Prescription Medication: Physician Order and Parent Authorization** form or the **Self-Administration of Medication: Physician Order and Parent Authorization** form must be submitted at the start of the school year or when the medication becomes necessary. Self-administered prescriptions would include but not be limited to such medications as inhalers, epi-pens, insulin, or other emergency medications. (The prescription from the physician must specifically state that the student is to keep the medication on their person and administer the medication themselves.) Controlled substances (i.e. Ritalin) may not be self administered.

Prescription medication must come to school in the original container labeled for the student by a pharmacist in accordance with law and must be administered in a manner consistent with the instructions on the label.

Before any over-the-counter medication will be dispensed by anyone affiliated with the school district, a **Non-Prescription Medications: Authorization For Administration** form which has been signed by a parent or guardian of the student must be on file with the designated school representative. Over-the-counter medications must be provided to the designated school representative in the original labeled container. An over-the-counter medication will only be administered to a student according to the written directions on the bottle, unless contrary written directions from a physician are provided. If there is no specific age-appropriate dosage on the bottle, the medication will not be administered, unless contrary written directions from a physician are provided to the school.

The District reserves the right to review the continued use of any over-the-counter medication which has been prescribed by the parent or guardian. The District may require a physician's order for continued use of any over-the-counter medication.

When use of medication has ceased, or is no longer needed by the student, the parent or guardian is responsible to retrieve unused medications from the school. Any unused medications will be disposed of by the school upon the written request of the parent or guardian or at the end of the school year.

# ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

| Name: | Date: |
|---|---|
| Doctor: | Medical Record #: |
| Doctor's Phone #: Day | Night/Weekend |
| Emergency Contact: | |
| Doctor's Signature: | |

The colors of a traffic light will help you use your asthma medicines.

GREEN **means Go Zone!**
Use preventive medicine.

YELLOW **means Caution Zone!**
Add quick-relief medicine.

RED **means Danger Zone!**
Get help from a doctor.

Personal Best Peak Flow: _____

## GO

**You have *all* of these:**
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

**Peak flow:**
from _____
to _____

**Use these daily controller medicines:**

| MEDICINE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |
| For asthma with exercise, take: | | |
| | | |

## CAUTION

**You have *any* of these:**
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

**Peak flow:**
from _____
to _____

**Continue with green zone medicine and add:**

| MEDICINE | HOW MUCH | HOW OFTEN/ WHEN |
|---|---|---|
| | | |
| | | |
| | | |
| CALL YOUR ASTHMA CARE PROVIDER. | | |

## DANGER

**Your asthma is getting worse fast:**
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

**Peak flow:**
reading below _____

**Take these medicines and call your doctor now.**

| MEDICINE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

**GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!**
**If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.**
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.