FLORIDA DEPARTMENT OF HEALTH

Homer Rice
Administrator

LEON COUNTY SCHOOLS

Jackie Pons
Superintendent

Dear Parent/Guardian,

Your child has been identified as having asthma which may require treatment during the 2012-2013 school year. Enclosed are important documents that need to be **completed by you and the health care provider who is managing your child's asthma**. These documents provide a guide for your child's care during the school day. The Registered Nurse assigned to your child's school will provide training to designated school personnel based on this Medical Management Plan.

The following forms need to be completed and returned to the school health room as soon as possible:

- Asthma Management Plan (completed **and** signed by your child's health care provider)
- Consent for Sharing of Medical Information (check off each applicable agency **and** add other provider if not listed)
- Medication Permission Form (completed for each medication taken at school)

Additionally, the following are required if your child carries his/her inhaler:

- Authorization for Carrying an Inhaler (completed **and** signed by your child's health care provider)
- The inhaler must be properly labeled ***for your child*** with a prescription label including the child's name, name of the medication, dosage, time(s) of administration and physician name

Remember to keep copies of these documents for your records!

If you have any questions, please feel free to contact Leon County Health Department, School Health Division at 606-8150.

Sincerely,

Nancy Cooper, RN, BSN, NCSN

Nancy Cooper, RN, BSN, NCSN
School Health Coordinator
Leon County Health Department

Child Specific Training Log

School Year: _____

Student Name: _____ School: _____

Type of Training: _____

Date	Name/Title	RN Signature

Physician's Asthma Rescue Medication Orders for the 201___ - 201___ School Year

Student Name:_____ DOB:_____ Grade:_____

Allergies:_____ Medications:_____

School:_____ HR Teacher:_____

The following is to be completed by the PHYSICIAN:

CLASSIFICATION OF CONTROL	TRIGGERS
☐ Well Controlled ☐ Not Well Controlled ☐ Very Poorly Controlled	☐ Colds ☐ smoke ☐ Tobacco ☐ Exercise ☐ Dust ☐ Pesticides ☐ Weather ☐ Air Pollution ☐ Animals ☐ Birds ☐ Mold ☐ Cleansers ☐ Perfume/strong odors ☐ Cockroaches ☐ Other _____

Is Medication Needed For This Student Prior To Exercise?

15 Minutes before exercise, please give the following:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 1 Cough, Wheezing, Chest Tightness, or Some Problems Breathing

Please give the following & inform parent/guardian:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 2 If Worse (Symptoms Not Improving)

Please give the following & inform parent/guardian if it has been at least _____since last dose:

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

STEP # 3 Severe Symptoms (Severe Difficulty Breathing • Trouble Walking or Talking Due to Asthma Symptoms • Quick Relief Medicine Has Not Helped • Lips or Fingernails Blue or Gray)

Activate Emergency Plan:

1. **Call for 911 for an ambulance AND**
2. **Contact the parent / guardian AND**

*Give the following **Now** if it has been at least _____since last dose:*

MED NAME	DOSAGE OR NUMBER OF PUFFS	HOW OFTEN

Physician Signature	Physician Name	Phone Number	Date
Parent Signature	Parent Name	Phone Number	Date
LCHD RN Signature	LCHD RN Name	Phone Number	Date

LEON COUNTY SCHOOLS
MEDICATION PERMISSION FORM
(One form for each medication)

I hereby certify that it is necessary for _____ Date of Birth: _____
(Full Name of Student - List all names used by student)
Teacher/Homeroom: _____ Grade Level: _____
to be given the medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication, he/she will not be able to attend school.

Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved medicines will be accepted.

Name of Medication: _____

Reason for Medication (Diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning Date: _____ Ending Date: _____ Amount of Liquid or Count of Pills: _____

Emergency Telephone Numbers:

Parent/Guardian: _____ H: _____ W: _____ C: _____

Parent/Guardian: _____ H: _____ W: _____ C: _____

Doctor's Name: _____ Phone: _____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to school health personnel. This permission form is valid for the current school year only.

Parents are requested to pick up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded.

I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that the Leon County School District may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby authorize the School Board of Leon County, Florida ("LCSB") and Leon County Health Department ("LCHD"), and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration. I hereby release, indemnify, and hold harmless LCSB and LCHD and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, LCHD and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____
(Date) (Parent/Guardian Signature)

LEON COUNTY HEALTH DEPARTMENT

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from Leon County Health Department, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [X] Leon County Health Department
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____
Signature of Parent/Guardian or eligible student

_____
Date

Revised 5/12

LEON COUNTY SCHOOLS
AUTHORIZATION FOR CARRYING MEDICATION

Date: _____

To Whom it May Concern:

_____ is a student at _____.
(Name of Student) (Name of School)

It is medically necessary for him/her to carry the following medication(s)*:

Medication: _____
Reason for carrying: _____
_____

Medication: _____
Reason for carrying: _____
_____

Medication: _____
Reason for carrying: _____
_____

This authorization is valid for the current school year only (if for specific dates, please specify above). Additional information may be obtained from

_____
(Physician Name)

at _____ (Phone) or _____ (Fax)

Respectfully signed,

_____, M.D.
M.D. Signature or Office Stamp

*The student has demonstrated that he/she is responsible in the use and storage of the above medication(s).

_____ _____
LCHD School RN Date