STUDENT HEALTH HISTORY- ASTHMA

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Doctor: _____ Doctor's Numbers: _____

Allergies: _____

Parent/Guardian: _____ Phone #: _____

Parent/Guardian: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Daily Asthma Management Plan

Year diagnosed: _____ Date of most recent episode: _____

Triggers of an asthma episode in my child may include: *(please check all boxes below that may apply.)*

- **O** Exercise
- **O** Respiratory infections
- **O** Change in temperature
- **O** Animals
- **O** Food: Specify _____
- **O** Strong odors or fumes
- **O** Chalk Dust
- **O** Carpets in the room
- **O** Pollens

Other: (describe):_____

_____

_____

_____

Does your child take any asthma medications at <u>home</u>? Yes ____ No _____ If yes, please list:

	Medication	Dose	How often
1.			
2.			

*Please complete and sign reverse

Administer the emergency medications listed below in the event of an asthma episode at school.

Medication Authorization Forms must be completed and signed by parents and the prescribing physician-and be on file at the school before any medications may be administered Parent must bring medications to school.

	Medication	Dose	Describe When to Use
1.			
2.			

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: _____ _____

Signature Date

Reviewed by: _____ _____

School Nurse Date

****

FOR SCHOOL NURSE USE ONLY

Notes: _____

_____

_____

_____

Student Name_____

First Baptist Academy
Medication Authorization Form

Student's Name: _____ Sex: M ☐ F ☐ Date of Birth: _____

Teacher: _____ Grade: _____

Allergies: _____

MEDICATION INFORMATION

Medical Condition for which medication will be required for student in school: _____

Name of Medication: Prescription _____ Over-the-Counter _____

Route to administer (*please check one)* ☐ Oral (BY MOUTH) ☐ Topical (ON THE SKIN) ☐ Subcutaneous (INJECTED) ☐ Inhaled (BREATHED) ☐ IM Other _____

Dosage: _____ Frequency: _____ Time of Day: (ex.11:00 AM) _____

Is this a new medication? ☐ Yes ☐ No If yes, the first dose must be administered at home.

Special Instructions: _____

Prescription medications require healthcare provider signature below:
Physician's orders are required for <u>all prescription medications given at school</u>

Physician's Name (Print): _____ Phone Number: _____

Physician's Signature: _____ Date: _____ Fax Number: _____

☐ I have prescribed the student to ***self-carry*** MDI, pancreatic enzymes, EPI-PEN, or other life saving medications described on this page.

PARENT/GUARDIAN AUTHORIZATION

1. I give permission for my child's doctor to be contacted for information regarding the administration of the medication listed on this form.
2. I authorize the above medication to be administered as described or prescribed during school or after-school programs operated by Collier County Public Schools.
3. I understand that medication not picked up by the last day of school will be discarded.
4. I understand that medication may not be administered if either the "discard after date" or the manufacturer's expiration date has passed.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

Home phone: _____ Business phone: _____ Emergency phone number: _____

FOR SCHOOL NURSE USE ONLY

☐ Physician's Verbal Order Obtained: Date: ___ Time: _____ Received From: _____

Content of physician's verbal order obtained: _____

Reviewed by: _____ Date: _____

School Nurse

Please see reverse side of this document for Medication Authorization Information

First Baptist Academy Medication Authorization Form

Dear Parent/Legal Guardian:

If your child requires medication(s) during the school day, FBA requires that you provide authorization for all medications to be given. An authorization for prescription medication must also be completed and signed by a physician.

- The Medication Authorization Form on the reverse side of this document must be entirely completed and accompany prescribed or over-the-counter medications to be given to your child in school. The form must be signed by a parent/legal guardian. The prescribing healthcare-provider must also complete and sign the form for any **prescription** medications to be given.

- A parent/legal guardian or an authorized adult must deliver medications to the school. At the time of delivery, the quantity of each medication will be verified by the school nurse. **Please avoid sending medications to school with your child**.

- Medications given only one time per day or medications that can be given before or after school are not administered at school.

- Prescription medications must be received at school in a container with the **original**, unaltered prescription label attached. The l**abel must be written in English and** display all information required by law, including, but not limited to: date of prescription, “discard after date,” student's name, medication name, dosage, time to be administered, and the prescribing healthcare-provider's name.

- Medication may not be administered at school if either the “discard after date” **or** the manufacturer’s expiration date has passed.

- Over-the-counter (OTC) medications must be in the original sealed (unopened) store-issued container. Please label the container with your child's full name and birth date. OTC medications will only be given according to directions on the label. If a parent/ guardian requests dosages that do not appear on the non-prescription medication label, orders stating the reason for the administration variation must be obtained from the healthcare-provider by the parent/guardian and will be considered by a school nurse before administration may occur. **Based on the school nurse’s assessment, a parent may be required to obtain a physician’s authorization for increased and/ or daily administration of a non-prescription medication.**

- If your child is authorized to self-carry and use life saving medications as prescribed by his/her healthcare-provider, the child must demonstrate competency in self-administration/self-treatment and a “Contract for Self-Carried Medication” must also be completed and signed by the parent and school nurse. **Medication with current prescription label must be signed-in to school clinic.**

- **This Medication Authorization form is only valid for 1 school year. A new form must be completed for each school year.**

Please see reverse side of this document for Medication Authorization