ST JOSEPH
CATHOLIC SCHOOL

41 East First Street
Waconia, MN 55387
Phone: 952-442-4500 Fax: 952-442-3719
Email: schooloffice@stjosephwaconia.org

Dear Parent/Guardian,

It is that time of year again when we all start thinking about returning to school. We are preparing for the first day of school and our records indicate that your child has been diagnosed to have Asthma.

Good management of your child's asthma is important to his or her success at school. Clear communication between you, your child, your health care provider and school staff is the key to managing asthma at school. A written Asthma Action Plan developed by your healthcare provider and shared with the school will help keep your child safe at school. Following the Asthma Action Plan will enable your child to participate fully in school activities. We strongly advise that if your child has Asthma and they need an inhaler and/or nebulizer at school that you also supply all necessary equipment, including medications, nebulizer machine and tubing (check with school to see if they have a nebulizer machine) and a peak-flow meter to help us follow the asthma action plan correctly.

In addition to this cover letter, enclosed please find the:

- **Asthma Action Plan** – Please have your child's healthcare provider complete this form, sign and date and return to the school.
- **Self-Administration of Asthma Medication Authorization** – If you would like your child to self administer medications while at school please complete this form and return to the school. To complete this form please have your child's healthcare provider review and sign and provide parental/guardian permission by signing.
- **Parent Request for Medication Administration and Physician Order** – If you would like to have the school staff or Health Services administer any medications throughout the school year please complete this form, sign and date, review the Medication Administration Guidelines.

Please review, sign, date and return the enclosed forms to the school, along with any medications to be administered at school and give to the School office or Health Associate.

If you have questions, you may call school office.

Sincerely,

St. Joseph Catholic School

Asthma Action Plan

DATE: _____ /_____ /_____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: _____ /_____ /_____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

GREEN ZONE — DOING WELL — GO!

You have **ALL** of these:
- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

Peak Flow is between: _____ and _____

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH

YELLOW ZONE — GETTING WORSE — CAUTION

You have **ANY** of these:
- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

Peak Flow is between: _____ and _____

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE** **more than 6 hours,** or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have **ANY** of these:
- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: _____ and _____

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR** CALL **911** immediately.

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: _____ /_____ /_____ MD/NP/PA SIGNATURE _____

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable)*.

DATE: _____ /_____ /_____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

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AUTHORIZATION TO SELF-CARRY/SELF-ADMINISTER MEDICATION

Prescription asthma, epinephrine auto-injectors and other emergency medications.

TO BE RENEWED EACH SCHOOL YEAR

To be completed by Prescribing Health Professional

I believe that _____ is capable of self-carrying/self/administering the following medication(s): *Note: only the following prescription medications are allowed for student self-carry/administer – prescription asthma medications, prescription epinephrine, and/or other necessary emergency medications.*

Medication	Route	Dose	Frequency
Medication	Route	Dose	Frequency

I recommend self-carrying and self-administration of this medication(s) for the treatment of: _____

Comments: _____

_____

Discontinuation date: _____

_____
Signature of Prescribing Health Professional

Printed Name	Phone	Date

To be completed by Parent/Guardian

I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication(s). I understand that if my child misuses by not takin the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-carry/self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional/clinic.

Signature of Parent/Guardian	Date
Work phone number or other daytime phone number	Cell phone or pager number

Please complete reverse side →

To be completed by Student – Student Agreement

Medication is permitted in accordance with district policy and procedures. In addition to the parent/guardian, the student's licensed prescriber must authorize self-carry and self-administration of medication(s). Student name must appear on the medication container, inhaler and/or injector.

I _____ agree to the responsibilities of carrying medication(s)

- ☐ Follow my health care provider's orders and Emergency Care Plan
  - Recognize correct dosage and proper timing for medication
- ☐ Refill my prescriptions before they expire (or remind my parent/guardian to do so)
- ☐ Use correct medication administration technique (demonstrate to nurse)
  - ☐ Not allow anyone else to use my medication
  - ☐ Keep a current supply of my medication, located:_____
- ☐ Notify the school nurse or_____ under the following circumstances
  - Questions or concerns regarding medication
  - Suspect that I am experiencing side effects from the medication and/or am having an allergic reaction
  - Symptoms continue to get worse after taking my medication

_____ _____

Signature of Student Date

To be completed by Licensed School Nurse/Health Associate

- ☐ This student has demonstrated mastery related to his/her medication and self-carrying skills
- ☐ This student needs reinforcement of his/her medication and self carrying-skills

The student **is / is not** able to demonstrate the specific responsibilities related to self-carrying and self-administration of medication(s). The student may carry the medication(s) unless and until he/she fails to follow the above agreement.

_____ _____

Signature of Licensed School Nurse/Health Associate Date

NOTE: Health Services will assess the student's competencies to self-carry and/or self-administer medication and if there are concerns, will contact the health care provider and parent to discuss further options. If agreement is not reached, the parents may contact the District Health Coordinator or School Administrator. Permission for self-carry/self-administration may be suspended if the student is unable to follow the above procedure.

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District 110 – Waconia Schools Medication Guidelines

School District 110 acknowledges that some students may require prescribed and over the counter medications during the school day to function as near to their potential as possible. For more information please refer to ISD 110 Student Medication Policy #516 and Medication Administration in the School Setting Procedure. The school district's licensed school nurse, health associate, or other designated trained school employee will administer prescribed medications under these conditions:

- **Prescription and non-prescription medication requires a completed signed authorization form from the student's parent/guardian. For prescription medications a physician is required**, for non-prescription/over the counter medications health services recommends a physician signature. The school district may rely on an oral request to administer medication for up to two days until written authorization is received. It is to include:
  - Student name
  - Name of medication
  - Time of administration
  - Possible side effects
  - Dosage and route of administration
  - Termination date of administration
  - Reason for medication
  - Number of tablets sent to school

This authorization can be faxed to the health office of your child's school.
Fax Numbers: High School (952)442-0679, Clearwater Middle School (952)442-0659, Laketown Elementary (952)442-0699, Southview Elementary (952)442-0629, Bayview Elementary (952)442-0609

- **Prescription or non-prescription medication must be in the prescription or over-the-counter labeled container and should be brought to school by a parent/guardian.** The pharmacy will divide medication for home and school into two bottles with proper labels.

- **Parent/Guardian will notify the Health Office of any changes in medication or if it is discontinued.** A written script from the physician will be needed for any changes. This can also be faxed to the appropriate school.

- **The school WILL NOT provide any medications including Aspirin, Tylenol, Ibuprofen, cough drops, Bacitracin (Neosporin), etc., in accordance with Minnesota Department of Health guidelines.**

- Students may be allowed to self-carry/self-administer prescription asthma medications and prescription epinephrine. In addition, secondary students (7^{th}-12^{th}) may be allowed to self-carry/self-administer non-prescription pain relievers in a manner consistent with labeling. No student will be allowed to self-carry/self-administer any medication without a written plan agreed upon between the licensed school nurse, health associate, parent and licensed prescriber (if necessary).

- **District 110 prefers not to administer Investigational, Complementary and Alternative Medicines not approved by the FDA.** The quality and quantity of non FDA approved products are free from the scrutiny of a regulatory agency. The labels also do not indicate the action, recommended dosage for age, side effects, interactions, adverse reactions and contraindications. A licensed prescribers order is needed to administer any non-FDA approved medications. See Medication Administration in the School Setting Procedure for more information.

NOTE: Health Services will not give the first dose of medication to any student.

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Parent Request for Medication Administration and Physician Order

Parents of pupils requesting that medication be administered during school hours must provide for the school:

- Medication in an appropriately labeled container, over the counter medications must be in original container and prescription medications in a prescription bottle.
- Parent/guardian signature.
- A physician signature for prescription medications. *Note: Health services recommends a physician signature for non-prescription medications.*

Ask for prescription medications to be divided into two bottles completely labeled – one for home and one for school. Only when a medication is prescribed to be taken during school hours will a student be given medication at school.

*Please review the **"District 110 Medication Policy"** on the back of this form.*

Student Name:_____ **Birth date:**_____ **School:**_____

Gr:_____ **Medication:**_____ **Route: Oral** ____ **Inhaled**____ **Topical**____

Dosage:_____ **Time Given:**_____

Treatment Of:_____ **Number of tablets sent to school:**_____

Possible Side Effects:_____

Special Instructions:_____ **End Date/Number of days given:**_____

Allergies:_____

I request that this medication be given as indicated above. I understand that administration of medication will not necessarily be done by a Licensed School Nurse or Health Associate, but may be provided by a designated trained school employee. Also, if necessary, the school may request additional information from the physician regarding this illness or medication.

Sign form below and return it with the medication to the school health office.

PARENT/GUARDIAN SIGNATURE:_____

Date:_____ **Daytime Phone:**_____

PHYSICIAN SIGNATURE:_____

Print Physician Name:_____ **Phone/Fax:**_____

Below line for School Health Office Use only:

Date/Time Dose/Initials	Date/Time Dose/Initials	Date/Time Dose/Initials	Date/Time Dose/Initials	Administrator Signature

In partnership with family, parish and the community, St. Joseph Catholic School serves God and community by educating Pre-K through 8th grade students. The school develops the whole child by providing an education integrated with traditional Catholic values and spirituality.