Boone County Schools
School Health Services Department

Asthma Health Care Plan

Plan Date: _____ School Name: _____

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

Asthma Triggers	Asthma Symptoms
€ Respiratory infection	€ Wheezing
€ Exercise	€ Coughing
€ Allergic reaction	€ Shortness of breath
€ Exposure to cold of 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
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 ☐

Comments: _____

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

_____

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

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Boone County Schools
School Health Services Department
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 SELF-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 SELF-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.

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