DEPARTMENT OF NURSING
TOWN OF TRUMBULL

Asthma Action Plan, Care Plan, Order Form

Student's Name_____ Date_____ Date of Birth_____

School_____ Grade_____ Teacher_____

Parents_____ Home Phone_____ Work Phone_____

Date when Asthma was Diagnosed_____

Severity- Severe Persistent_____ Moderate Persistent_____ Mild Persistent_____ Intermittent_____

What triggers your child's asthma attacks? (Please check any that apply.)

☐ Illness ☐ Emotions ☐ Medications ☐ Foods
☐ Weather ☐ Exercise ☐ Cigarette Smoke ☐ Chemical Odors
☐ Fatigue

Allergies (please list)_____

What symptoms does your child exhibit when having an asthma attack?

☐ No symptoms ☐ Cough ☐ Wheeze ☐ Chest Tightness ☐ Facial Changes ☐ Other_____

Please list the medications your child takes for asthma at Home

*Name of Medication*_____

*Dose*_____ *Frequency*_____

Medication to be administered at school

Drug Name_____ Dose_____ Route_____

Time of Administration_____ If PRN, Frequency_____

Relevant Side effects_____

Medication shall be administered from_____ to_____ Prescriber's Name_____ Phone_____

Prescriber's Signature_____ Date_____

Spacer - yes____ No___

Parent/Guardian Authorization_____ Date_____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a chronic medical condition, self-administration of emergency and some other non-controlled medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration:___yes____no_____
Signature Date

Parent/Guardian authorization for self administration:_____yes____no _____
Signature Date

School Nurse approval for self administration:___NR*____yes____no_____
Signature Date

_____

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a prescription or over-the-counter medication during the school day or during intramural or interscholastic athletic events, you must follow the procedures required by Trumbull Public Schools, Connecticut General Statute, Sec. 10-212a, and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-9. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, physician assistant or optometrist) using Trumbull's Public Schools' form, *Authorization for the Administration of Medicine by School Personnel.* A new order is required each year and, if so prescribed, may be effective from July 1st through June 30th of the given year. A medical order dated July 1 of a year will cover summer programs and the upcoming school year.

2. The authorized prescriber must fill in the information requested on the form:
   a) Name of medication, the generic name of the medication (NEW), and strength of the medication;
   b) Indication(s) for the administration of this medication in school (condition, diagnosis);
   c) Amount (dosage) of the medication to be administered and route of administration.
   d) Potential side effects of the medication;
   e) Time of day that the medication is to be administered; and frequency for PRN (as-needed) medications
   f) Duration of the order for administration of the medication (up to 12 months from July 1 through June 30th of the same school year).
   g) If applicable, authorization for self-administration in school.

3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form and, if applicable, provide authorization for self-administration in school.

4. The medication must be packaged in the ORINGINAL PHARMACY CONTAINER, clearly labeled with the student's name, the authorized prescriber's name, and the prescription.

5. The medication and completed authorization form must be delivered to the school nurse by a responsible adult, except that, once the nurse has reviewed the medical order and developed a plan for self-administration, the student is responsible to carry the medication to/from school each day and maintain its safe control at all times.

6. Self administration plans approved for the school day also extend to extra curricular activities and athletics.

7. Self administration of controlled medication is not permitted.

8. No more than a three (3) month supply may be stored at school. Unused medication must be destroyed if not picked up by a responsible adult by the end of the last day of school

It may be helpful to take this authorization form (side one) with you to your healthcare provider in case medication is prescribed for your child.

Thank you for your cooperation. Please contact the school nurse if you have any questions.

Record of medication received

DATE	COUNT	PARENT/ADULT SIGNATURE	SCHOOL NURSE SIGNATURE