



Instructions for the School Medication Prescriber/Parent Authorization Form (PPA) & Management Plan, (IHP) Individualized Healthcare Plan, (EAP) Emergency Action Plan, and (CAP) Classroom Action Plan for ASTHMA

1. (IHP) Individualized Healthcare Plan/(EAP) Emergency Action Plan/(CAP) Classroom Action Plan

- Section I – Parent/Guardian must complete.
- Section II – Physician, Physician’s Assistant, or Nurse Practitioner must complete.
- Signatures - Parent/Guardian, Physician, Physician’s Assistant, and/or Nurse Practitioner must sign and date.

**Alabama Board of Nursing requires the following to be completed on all (PPAs) for each Med/Dose*

2. School Medication Prescriber/Parent Authorization Form (PPA)

- **Prescriber Authorization Section: (Prescription & Over-the-Counter Medications)**
 - **Every blank must be completed** to include: med, dosage, time, route, start and stop dates, reason, special instructions, sign and date,
 - Med(s) will not be accepted or administrated with an incomplete and/or incorrect PPA,
 - Complete one PPA for each med & each dose,
 - Start Date and Stop Date - Please list specific dates,
 - Use as Directed instructions will not be accepted - must be specific,
 - Frequency/Time(s) to be given – “as needed”, please include time parameters (example: every 4 hours as needed), and
 - Self-Administer/Self-Carry - Only med(s) to prevent &/or treat medical emergencies are acceptable.
- **Parent/Guardian Section**
 - **Student Information Section-** Parent/Guardian must complete every question including: allergies, weight and birth date,
 - **Parent Authorization Section-** Parent/Guardian must sign and date, and
 - **Self-Administration Authorization Section-** Parent/Guardian must sign and date to allow student to self-medicate and/or self-carry approved med at school.

Parent/Guardian must bring in PPA(s), medication(s), and management plan(s) directly to the school nurse or designated medication assistant. Students, unless prescribed to ‘Self-Administer/Self-Carry’, may not bring in their own medication(s). All medications (to include over-the-counter & prescription) must be counted and logged-in each time.

Expired Medication(s): Please be aware of medication expiration dates. You will be notified when your child’s med expires.

End of School Year: All medication(s) must be signed out at the end of the school year. Medication(s) left in the clinic after that time will be discarded according to federal and state guidelines.

Sincerely,

School Nurse

If you have received this packet in error, or if your student’s medical condition does not require emergency planning, please sign below and return this form to your child’s teacher or school nurse.	
<input type="checkbox"/> Received in error	<input type="checkbox"/> Student’s medical condition does not require medication and/or emergency planning

Student Name: _____

Comments: _____

Parent/Guardian Signature: _____ Date: _____

HCS School: _____ Start Date: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN for ASTHMA WITH MEDICATION AT SCHOOL

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan

SECTION I – Parent (Please Print):

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Emergency Contact: _____
Name Cell # Home # Work #

Emergency Contact: _____
Name Cell # Home # Work #

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ Policy/Group # _____
(optional) (optional)

SECTION II – Physician (Please Print)

SCHOOL PLAN:

If student "self-carries" medication, a "back-up" medication to be kept in clinic? YES NO

IF YOU SEE THIS...

DO THIS...

Student complains of: Tightness in chest, Coughing, Wheezing, Other: _____ Other: _____	*1. Med/Dose: _____ 2. Route: Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> 3. Observe student for change in condition. DO NOT leave student unattended. 4. Allow student to return to class if symptoms relieved after medication.
If no change in symptoms after 15 minutes of medication administration.	*1. Med/Dose: _____ 2. Route: Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> 3. Call parent about student using medication x2 4. Maintain student in sitting position
If no improvement in symptoms after second dose of medication and unable to contact parent/guardian after second dose is administered.	1. Call 9-1-1 (Continue trying emergency contacts) 2. Encourage slow deep breathing, rest 3. Maintain student in sitting position
Student is hunched over, has difficulty breathing, is unable to speak, uses neck/shoulder muscles to assist in breathing effort, lips and/or nail beds are blue in color.	1. Call 9-1-1, student should remain in a sitting position 2. Call parent/guardian or emergency contact 3. Rest, reassurance, calm slow deep breathing 4. Remain with student
If student becomes unconscious...	1. Call 9-1-1 Remain with student 2. Call parent/guardian or emergency contact

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER
FIELD TRIPS: The inhaler should NOT be left in a backpack on the bus or with a teacher who is not with the student.

BUS PLAN: Recognize Symptoms, Pull Over, Call 911, & Parent/Guardian.
Only self-carry/self-administer medications will be available.

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

Physician Signature _____ Date _____ Parent Signature _____ Date _____ Student Signature _____ Date _____ Nurse Signature _____ Date _____

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____
 Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____
 No known drug allergies---if drug allergies list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ Dosage: _____ Route: _____
 Frequency/Time(s) to be given: _____ Start Date: ____/____/____ Stop Date: ____/____/____

Reason for taking medication: _____
 Potential side effects/contraindications/adverse reactions: _____
 Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
 Is self-medication permitted and recommended? Yes No
 If "yes" I hereby affirm this student has been instructed
 On proper self-administration of the prescribe medication.
 Do you recommend this medication be kept "on person" by student? Yes No

Printed Name of Licensed Healthcare Provider: _____ Phone: () _____ - _____ Fax: _____ - _____
 Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ Date: ____/____/____ Phone: () _____ - _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/____ Phone: () _____ - _____