Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
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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.

☐ Received in error ☐ Student's medical condition does not require medication and/or emergency planning

Student Name: ______________________________

Comments: ______________________________

Parent/Guardian Signature: ______________________ Date: __________

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HCS School: ______ School District: ______ School Hours: ______
Onsite Nurse Name: ______ Start Date: ______ Extracurricular Hours: ______
Onsite Nurse Phone# ______ Stop Date: ______ Extracurricular Activity: ______

MANAGEMENT PLAN for ASTHMA WITH MEDICATION AT SCHOOL

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

SECTION I –PARENT (Please, Print) **IEP?** ❑ YES ❑ NO **504?** ❑ YES ❑ NO

Student Name: ______ DOB: ______ Teacher/Grade: ______
Student Home Address: ______
Known Allergies/Triggers: ______ WT ______ HT ______
Medications Taken at Home: ______
Potential Side-Effects of Home Meds: ______
Bus Transportation ❑ YES ❑ NO Bus # a.m. ______ Bus # p.m. ______ Fieldtrip/Extracurricular Bus Transportation ❑ YES ❑ NO

Parent/Guardian Contact: ______ Name ______ Cell # ______ Home # ______ Work #
Parent/Guardian Contact: ______ Name ______ Cell # ______ Home # ______ Work #
Emergency Contact: ______ Name ______ Cell # ______ Home # ______ Work #

Physician: ______ Phone#: ______ Fax#: ______
Physician Address: ______ Preferred Hospital: ______
Insurance Provider: ______ (optional) Policy/Group # ______ (optional)

SECTION II –PHYSICIAN (Please, Print): EMERGENCY ACTION PLAN (EAP)

A signed medication PRESCRIBER/PARENT AUTHORIZATION (PPA) FORM is required for each medication

Is a medication PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? ❑ YES ❑ NO

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

The severity of symptoms can change quickly and potentially progress to a life threatening situation.

IF YOU SEE THIS...	DO THIS...
Student complains of: • Tightness in chest • Coughing • Wheezing • Gasping for Air • Prolonged Expiration • Change in Color of Skin (Pale or Blue)	*Medication: ______ Dosage: ______ 1. Route: ❑ Inhaler ❑ Nebulizer 2. Observe student for change in condition. DO NOT leave student unattended 3. Allow student to return to class if symptoms are relieved/improved after medication
If no change in symptoms after 15 minutes of medication administration:	*Medication: ______ Dosage: ______ 1. Route: ❑ Inhaler ❑ Nebulizer 2. Call parent about student using medication x2 3. Have student maintain sitting position 4. Limited physical activity
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 immediately. Continue to try Emergency Contacts 2. Encourage slow, deep breathing & rest 3. Have student maintain sitting position
Student complains, 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 immediately. Student should remain in sitting position 2. Call Parent/Guardian or Emergency Contact 3. Rest, reassurance & calm, slow, deep breathing 4. Remain with student
If student becomes unconscious:	**If no improvement:** 1. Call 9-1-1 immediately. Be prepared to perform CPR 2. Call Parent/Guardian or Emergency Contact

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital, 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 & 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

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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:** ( ) ______-_______