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Formulario de Autorización, Instrucciones y Plan de Manejo del Medicamento Otorgado por el Médico/Padre de Familia a la Escuela (PPA), Plan Individual de Cuidados de Salud (IHP), Plan de Acción de Emergencia (EAP), y Plan de Acción para el Salón de Clases (CAP) por ASTHMA

1. **(IHP) Plan Individual de Cuidados de Salud/(EAP) Plan de Acción de Emergencia/(CAP) Plan de Acción para el Salón de Clases**
   - Sección I – Padre/Tutor debe completar.
   - Sección II – Médico, Asistente del Médico, o Enfermera(o) calificada(o) debe firmar y escribir la fecha.
   - Firmas – Padre de Familia/Tutor, Médico, Asistente del Médico, y/o Enfermera(o) Calificada(o) debe firmar y escribir la fecha.

**El Consejo de Enfermería de Alabama exige que lo siguiente sea llenado en su totalidad para cada (PPAs) Medicamento/Dosis.*

2. **Formulario de Autorización Otorgado a la Escuela por el Médico/Padre de Familia (PPA).**
   - **Sección de Autorización del Médico que Receta: (Medicamentos con y/o sin Receta)**
     - **Cada espacio vacío debe ser llenado** para incluír: medicamento, dosis, horario, vía de suministro (oral, nasal, etc.) fechas de comienzo y terminación, razón, instrucciones especiales, firma y fecha.
     - Ningún Medicamento será aceptado ni suministrado si el formulario (PPA) está incompleto y/o incorrecto.
     - Llene un Formulario (PPA) para cada medicamento y para cada dósis.
     - Fecha de Comienzo y Fecha de Terminación – Por favor mencione las fechas específicas.
     - Eso de *"Usarse de acuerdo a las instrucciones"*, no será aceptado – debe ser específico.
     - Horario de suministro – *"como sea necesario"*, por favor incluya parámetros de tiempo (por ejemplo: cada 4 horas si es necesario, etc.), y
     - El Auto suministro/hecho de llevar consigo medicamentos – Unicamente será permitido para tratar y/o prevenir emergencias.
   - **Sección del Padre/Tutor.**
     - **Sección de Información del Estudiante –** El Padre/Tutor debe contestar por escrito cada pregunta incluyendo: alergias, peso y fecha de nacimiento,
     - **Sección de Autorización del Padre –** El Padre/Tutor debe firmar, poner la fecha y
     - **Sección de Autorización para el Auto suministro de medicamentos** – El Padre/Tutor debe firmar y poner la fecha donde autoriza a su hijo/a, el auto suministro y/o el hecho de llevar consigo el medicamento a la escuela.

El Padre /Tutor debe traer (directamente a la enfermera de la escuela ó a la persona asignada para suministrar medicamentos), un Formulario de Autorización del Médico y/o del Padre de Familia (PPA(s)); medicamento(s), e instrucciones de suministro. Los Estudiantes, no deben, a menos que estén autorizados para auto suministrarse y/o llevar consigo, su(s) propio(s) medicamento(s). Todo medicamento (incluyendo recetado y no recetado) debe ser contado y registrado cada vez.

Medicamentos vencidos: Por favor esté pendiente de las fechas de vencimiento de sus medicamentos. Usted será notificado(a) cuando el medicamento de su hijo(a) se venza.

Fin del Año Escolar: Todo medicamento debe ser recogido y firmar de recogido, al final del año escolar. Después de este tiempo, todo medicamento dejado u olvidado en la clínica de la escuela será desechado de acuerdo al reglamento estatal y federal.

Sinceramente,

Enfermera de la Escuela

Si usted ha recibido este paquete por equivocación, o si la condición médica de su estudiante no necesita de un plan de emergencia, por favor, firme y regrese este formato a la maestra de su hijo(a) o a la enfermera de la escuela.

☐ Recibido por equivocación ☐ La condición médica del estudiante no necesita ni medicamento, ni plan de emergencia.

Nombre del Estudiante: _____

Comentarios: _____

Firma del Padre/Tutor: _____ Fecha: _____

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

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:** ( ) _____-_____