Tyrone Area
School District

SECTION: PUPILS

TITLE: POSSESSION/USE OF ASTHMA INHALERS

ADOPTED: JANUARY 10, 2006

REVIEWED: NOVEMBER 2008

210.1 POSSESSION/USE OF ASTHMA INHALERS

1. Authority

The board shall permit students to possess asthma inhalers and to self-administer the prescribed medication used to treat asthma when such is parent-authorized.

SC 1414.1

Possession and use of asthma inhalers by students shall be in accordance with state law and board policy.

2. Definitions

Asthma inhaler shall mean a prescribed device used for self-administration of short-acting, metered doses of prescribed medication to treat an acute asthma attack.

Self-administration shall mean a student's use of medication in accordance with a prescription or written instructions from a physician, certified registered nurse practitioner or physician assistant.

3. Guidelines
SC 1414.1
Title 22
Sec. 7.13

Before a student may possess or use an asthma inhaler during school hours, the board shall require the following:

1. A written request from the parent/guardian that the school complies with the order of the physician, certified registered nurse practitioner or physician assistant.

2. A statement from the parent/guardian acknowledging that the school is not responsible for ensuring the medication is taken and relieving the district and its employees of responsibility for the benefits or consequences of the prescribed medication.

3. A written statement from the physician, certified registered nurse practitioner or physician assistant that states:

   A. Name of the drug.

   B. Prescribed dosage.

   C. Times medication is to be taken.

   D. Length of time medication is prescribed.

   E. Diagnosis or reason medication is needed, unless confidential.

	F. Potential serious reaction or side effects of medication. G. Emergency response. H. If child is qualified and able to self-administer the medication. The student shall be made aware that the asthma inhaler is intended for his or her use only and may not be shared with other students. The student shall notify the school nurse immediately following each use of an asthma inhaler. Violations of this policy by a student shall result in immediate placement of the student in an administrative office with parental contact. Pending on the situation, such violations by the student may result in immediate confiscation of the asthma inhaler and medication and loss of privileges.
SC 1401	The district reserves the right to require a statement from the physician, certified registered nurse practitioner or physician assistant for the continued use of a medication beyond the specified time period. Permission for possession and use of an asthma inhaler by a student shall be effective for the school year for which it is granted and shall be renewed each subsequent school year.
SC 1414.1	A student whose parent/guardian completes the written requirements for the student to possess an asthma inhaler and self-administer the prescribed medication in the school setting shall demonstrate to the school nurse the capability for self-administration and responsible behavior in use of the medication. To self-administer medication, the student must be able to: 1. Response to and visually recognize his or her name. 2. Identify his or her medication. 3. Demonstrate the proper technique for self-administering medication. 4. Sign his or her medication sheet to acknowledge having taken the medication. 5. Demonstrate a cooperative attitude in all aspects of self-administration.
4. Delegation of Responsibility	The superintendent or his designee, in conjunction with the school nurse(s), shall develop procedures for student possession of asthma inhalers and self-administration of prescribed medication. The district shall annually inform staff, students and parents/guardians about the policy and procedures governing student possession and use of asthma inhalers.

When an asthma inhaler is initially brought to school by a student, the school nurse shall be responsible to complete the following:

1. Obtain the required written request and statements from the parent/guardian and physician, certified registered nurse practitioner or physician assistant, which shall be kept on file in the office of the school nurse.

2. Review pertinent information with the student and/or parent/guardian, specifically the information contained on the statement submitted by the physician, certified registered nurse practitioner or physician assistant.

3. Determine the student's ability to self-administer medication and the need for care and supervision.

4. Maintain an individual medication log for all students possessing asthma inhalers.

REFERENCES:

School Code - 24 P.S. Sec. 1401, 1414.1

State Board of Education Regulations - 22 PA Code Sec. 7.13

TYRONE AREA SCHOOL DISTRICT
Asthma Action Plan

HR _____
PE _____

Student: _____ DOB: _____ Grade: _____

Emergency Information:

Mother's Name _____ Home Phone _____
Work Phone _____ Cell Phone _____
Father's Name _____ Home Phone _____
Work Phone _____ Cell Phone _____
Other Emergency Contact _____ Home Phone _____
Work Phone _____ Cell Phone _____
Physician treating this student's asthma _____ Phone _____
Other Physician _____ Phone_____

Current Medications:

Daily Asthma Medication

Name: _____ Dose: _____ Times: _____
Name: _____ Dose: _____ Times: _____
Name: _____ Dose: _____ Times: _____

Rescue/As Needed Asthma Medication

Name: _____ Dose: _____ Frequency: _____
Taken by ___ mouth ___ inhaler ___ nebulizer

Other Medications

Name: _____ Dose: _____ Times: _____
Name: _____ Dose: _____ Times: _____
Name: _____ Dose: _____ Times: _____

Allergies:

_____

Triggers: (Check if applicable for your child.) __ illness __ stress __cold air __ smoke __ dust __ odors __ animals __ food __ exercise __ other _____

Peak Flow Meter Reading, personal best _____
Days missed from school last year due to asthma _____
Times treated in emergency room in past year due to asthma _____

Signs of acute asthma episode:

difficult and/or rapid breathing
wheezing
excessive coughing
complaints of chest tightness
nasal flaring
use of stomach/neck/chest muscles to breathe
inability to speak full sentences
peak flow less than _____
other _____

Signs of asthma emergency:

continued or severe difficulty in breathing
progression of symptoms despite use of rescue medication
difficulty talking
blue or gray discoloration of lips or fingernails
peak flow less than _____
other _____

Action for asthma attack:

remove from trigger/environmental issues
contact school nurse
peak flow, if applicable
use of rescue medication
sit quietly in upright position, slow deep breaths in nose, out mouth
other _____
contact parent if _____

Action for asthma emergency:

call 911
contact parent if not previously notified
other _____

Physician's Authorization

Instructions for Acute Asthma Episode: (Please include peak flow guidelines here or on reverse.)
1. _____

2. _____

3. _____

Physical Education/Recess Modifications:
___ Pre-treatment required
___ Other _____

Dietary Restrictions:
_____

Field Trip Modifications:
_____

Physician's Signature: _____ ***Date:*** _____

Parent's/Guardian's Authorization:

I give the School Nurse permission to consult (both verbally and in writing) with the above named student's physician regarding any questions that arise about the medical condition and/or medications, treatments, and/or procedures being used to treat the condition. ___ yes ___ no

- The school district intends to use the requested information to provide for your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed it may result in an incomplete health and safety plan for your child.
- Medications are not administered at school without physician and parent signatures.
- The information you provide will be shared only with district staff whose jobs require access to this information to ensure your child's safety and school success.

Parent's Signature: _____ ***Date:*** _____

School Nurse's Authorization:

This student is authorized to carry medication in a metered dose inhaler and self-administer per accompanying form. ___ yes ___ no

School Health Guidelines for Asthma Care

Nursing Diagnosis:		Goal:	
1.	Potential for ineffective breathing pattern	1.	Student will manage the symptoms of asthma as directed.
2.	Potential for activity intolerance	2.	Student will self-limit activities as needed and attend school regularly.
3.	_____	3.	_____
4.	_____	4.	_____

Nurse's Signature: _____ ***Date:*** _____

ASTHMA INHALERS: SELF-ADMINISTRATION BY STUDENTS

_____ _____ _____

Student's Name Grade Date

To self medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self-administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____

Name of Medication Dosage Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

_____ _____

Date Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

_____ _____

Date Student's Signature

TYRONE AREA SCHOOL DISTRICT
MEDICATION CONSENT FORM

THE FOLLOWING INFORMATION MUST BE PROVIDED IN ORDER FOR ANY MEDICATION, PRESCRIPTION OR OVER-THE-COUNTER, TO BE ADMINISTERED.

NAME OF STUDENT:_____

DIAGNOSIS:_____

NAME OF MEDICATION:_____

DOSAGE:_____TIME:_____

SPECIAL INSTRUCTION:_____

POSSIBLE SIDE EFFECTS:_____

IS STUDENT CAPABLE OF SELF ADMINISTRATION:_____

STARTING DATE:_____ENDING DATE:_____

_____ _____
PHYSICIAN'S SIGNATURE DATE

_____ _____
PHYSICIAN'S TELEPHONE # PHYSICIAN'S FAX #

ATTENTION: ALL MEDICATION MUST BE SENT TO SCHOOL IN THE ORIGINAL PHARMACY CONTAINER. OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN ITS ORIGINAL CONTAINER. MEDICATION <u>CANNOT BE DISPENSED FROM UNLABELED CONTAINERS</u>.

PARENTAL PERMISSION: I hereby give my permission for a school nurse or other designated person of the Tyrone Area School District to administer medication to my child or to assist in self-administration as prescribed by his/her physician and as outlined on this form. I agree to release the Tyrone Area School District personnel of all responsibility in terms of my child taking this prescription/over-the-counter medication during the school day.

_____ _____
PARENTAL SIGNATURE DATE

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