FREEDOM AREA SCHOOL DISTRICT

Freedom Area School District
Health Services
Amie Kazik RN, BSN, District Nurse
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Student's Name:	**DOB:**	Date:
School:	Grade:	Bus Student: Yes No

Co-Curriculars:

Health Condition: **Respiratory- Emergency Care for Diagnosis of:**
______ Asthma- Please circle: Mild Moderate Severe
______ Other:

Emergency Plan: Emergency Action is Necessary when the student has symptoms such as:

Steps to take during a breathing emergency: DO NOT LEAVE STUDENT UNATTENDED!

1. Calmly instruct students to take deep breaths.
2. Give medication as listed below. Students should respond to treatment in 15-20 minutes.
   _____ Medication kept in office
   _____ Student carries their own inhaler at school
   _____ No medication kept at school
3. Contact parents if: ____
4. Seek emergency medical help now if the student has any of the following:
   a. Coughs constantly
   b. No improvement 15-20 minutes after the initial treatment with medication and a relative cannot be reached
   c. Hard time breathing with:
      i. Chest and neck pulled in with breathing
      ii. Struggling or gasping
      iii. Nose flares open wide
      iv. Stooped body posture
      v. Breathing is hard and fast
      vi. Ribs showing with breath
   d. Can not walk or talk
   e. Stops playing and can't start activity again
   f. Lips or fingers are gray or blue
   g. Student has no inhaler available at school/activity

Emergency Medications:

Name:	Amount:	When to Use:

Parent/Emergency Contact Information:

Name	Relationship to Student	Phone

***Note: Please update the health services team throughout the year of any changes in phone number and/or emergency contacts.**

Please identify the things that may start a breathing emergency: (Ex. Animals, changes in temperature, viral, etc.)

Please list any environmental control measures, pre-medications and/or dietary restrictions that the student needs to prevent an emergency episode:

Daily Medication Plan:

Name:	Amount:	When to Use:

FOR COMPLETION BY PHYSICIAN: Physician's Name: Phone:

Diagnosis:

Name of Medication:

Form:	Dosage:

Is the student knowledgeable about their medication: ________Yes ________ No
Has the student demonstrated the proper technique in administering medication: _____Yes ______No
In your professional opinion should this student be allowed to carry and self administer their medication:
______ Yes _______ No

Medicine administered daily: _______ Yes _______ No If Yes, what time:_________

Medicine is administered when needed. Indications:

If needed, how soon can administration of medicine be repeated:
The medication can not be repeated more than:

Side effects:

Physician Signature: Date:

Medication Consent: I hereby give permission to designated trained school personnel to give medications to my student during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the student's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold the Freedom Area School District employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when changes in the above orders are necessary. If self-administration is allowed, or if no authorized staff member is available, I ask that my student be permitted self-medication as authorized by my physician and myself. I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after hours and traveling to/from and during school-sponsored events.

Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff, and other pertinent FASD staff.

By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent's Signature:	Date: