

**OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM**

ASTHMA ACTION PLAN

9020.05F

PHYSICIAN/PARENT AUTHORIZATION for SELF ADMINISTRATION

Student: _____ DOB: _____

School/Grade: _____ Current Age: _____

**PHYSICIAN AUTHORIZATION for SELF-ADMINISTRATION BY STUDENT
Physician and Parent/Guardian Signature required per KRS 158.834**

Diagnosis – **ASTHMA:** Controlled Chronic Acute w/illness Seasonal

Medication/Inhaler: _____ Dosage: _____

This student has been instructed by PHYSICIAN regarding the care, storage and use of this prescribed medication and has the ability to determine appropriate administration of the medication. The medication must be carried on the student’s person and will be labeled with the student’s name.

This student had been instructed by PHYSICIAN that if symptoms are not relieved by medication administration, STUDENT must notify a school staff member or other supervising adult immediately.

Printed Name of MD, DO, ARNP or PA

FAX number

Signature of MD, DO, ARNP or PA

Telephone

Date

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION BY STUDENT

Signing this form shall release Oldham Co. Board of Education and its employees from liability for any injuries resulting from your student carrying, maintaining, and self-medicating. Parent/guardian agrees to hold harmless OCBE employees from any claim resulting from student’s self-administration of medication to treat Asthma per state law KRS 158.834. Parent/Guardian gives consent to Oldham County Board of Education employees to discuss the medical condition referenced above with physician to assist in planning for the student’s care while at school or school events. Permission for self-administration of medication shall be effective for the school year in which it is granted by Physician and Parent and shall be renewed each following school year.

Parent/Guardian of _____ AGREES that it is the responsibility of the parent/guardian to require the student to be in possession of the above prescribed medication during the school day, extracurricular activities and during field trips. Replacement of expired medication is the responsibility of the parent/guardian.

Signature of Parent/Guardian

Home Phone and Cell

Date

Emergency contact:

Phone:

Relationship:

EMERGENCY PLAN OF ACTION for STUDENTS WITH ASTHMA

1. **CALL EMS 9-911** if wheezing or coughing has not improved after medication administration by student; student is having difficulty breathing; student has trouble walking or talking; student’s fingernails, lips or gum line (darkened) are blue/ashen; student has any of the above symptoms and does NOT have access to medication documented above.
2. **NOTIFY** school personnel trained in CPR/AED to care for student and initiate CPR/AED if needed prior to EMS arrival. Notify parent/guardian or emergency contact. If student is transported via EMS, a school staff member must accompany student.