Phoenix Union High School District

ASTHMA HEALTH CARE ACTION PLAN AND PHYSICIAN ORDERS
PLAN DE ACCIÓN DE ATENCIÓN MÉDICA DEL ASMA Y PEDIDOS MÉDICOS

School Year (Año Escolar): _____ Grade (Grado): _____ Date of Birth (Fecha de Nacimiento): _____

Student Name (Nombre de Alumno): _____ Student ID #: _____

Parent/Guardian Name (Nombre de Padre/Madre/Tutor): _____

Cell Phone (Teléfono Cellular): _____ Work (Trabajo): _____ Home (Casa): _____

Physician (Nombre del Medico): _____ Phone (Teléfono): _____

The parent/guardian agree and understand that they are responsible for maintenance of equipment, furnishing all equipment, medications, and supplies necessary in providing services to the student during school hours. The parent/guardian is also responsible for notifying the school nurse anytime there is a change in orders, medications, and/or in the student's medical condition.

I give permission for the school to allow my child to self-carry and self-administer prescribed medications during school hours and if assistance is necessary, allow authorized trained school personnel to administer medications and perform medical procedures as ordered by the physician/healthcare provider licensed in Arizona. I authorize the school to contact my child's physician/healthcare providers and/or dispensing pharmacies, should any questions, any additional orders and/or necessary documents be required for the care of my child during school hours.

El padre / tutor acuerda y entiende que es responsable del mantenimiento del equipo, el suministro de todo el equipo, los medicamentos y los suministros necesarios para proporcionar servicios al alumno durante el horario escolar. El padre / tutor también es responsable de notificar a la enfermera de la escuela cada vez que haya un cambio en las órdenes, medicamentos y / o en la condición médica del estudiante.

Doy permiso para que la escuela permita que mi hijo lleve consigo y autoadministre los medicamentos recetados durante el horario escolar y, si es necesaria, permita que el personal autorizado de la escuela administre los medicamentos y realice los procedimientos médicos según lo ordenado por el médico o proveedor de servicios de salud con licencia en Arizona. Autorizo a la escuela a ponerse en contacto con el médico de mi hijo / proveedores de atención médica y / o farmacias de entrega, en caso de tener preguntas, pedidos adicionales y / o documentos necesarios para el cuidado de mi hijo durante el horario escolar.

_____ _____

Parent/Guardian Signature (Firma de Padre/Madre/Tutor) Date (Fecha)

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FOR LICENSED PHYSICIAN/HEALTHCARE PROVIDER USE ONLY - PLEASE WRITE LEGIBLY

THE PHOENIX UNION HIGH SCHOOL DISTRICT IS REQUESTING YOUR ASSISTANCE IN COMPLETING THIS TWO-PAGE FORM TO IDENTIFY ANY SERVICES THAT WE MAY NEED TO PROVIDE TO THE STUDENT IN THE SCHOOL SETTING.

For breathing disorders, handheld inhaler devices may be carried for self-administration provided the student's name is on the prescription label, on the medication container, or on the handheld inhaler device and annual written documentation from the student's parent or guardian is provided that authorizes possession and self-administration. OTC medications (including vitamins) must be brought to school by the parent/guardian in the original container with all warnings and directions intact.

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Student Name: _____ School Year: _____

STUDENT MEDICAL DIAGNOSIS:_____
_____

COMMON TRIGGERS FOR ASTHMA

- ☐ Respiratory infection
- ☐ Increased physical activity
- ☐ Weather changes
- ☐ Stress or anxiety
- ☐ Animals: _____
- ☐ Strong odors such as perfume
- ☐ Smoke and/or pollution
- ☐ Dust or mold
- ☐ Pollens
- ☐ Food: _____

☐ Other triggers: _____

MEDICATION ADMINISTRATION AND PHYSICIAN ORDERS ☐ **SEE MEDICAL DOCUMENTS/ORDERS ATTACHED**

Must include name of medication, dose, route, administration time, or as needed. Medications brought to the school by the parent/guardian must be in the original labeled container dispensed by the pharmacy and must include a current pharmacy label with physician instructions and student's name.

_____
_____
_____
_____

ADDITIONAL SPECIAL INSTRUCTIONS AND PHYSICIAN ORDERS

_____
_____
_____

PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE REQUIRED BY THE SCHOOL

A school nurse is NOT always available on the school campus but trains authorized unlicensed assisted personnel (UAP) to care for ill and injured students, administer medications as ordered by the physician/healthcare provider and perform first aid rescue measures as needed.

☐ Student has been instructed and is **ALLOWED** to self-carry appropriate medications, monitoring equipment, and self-administer medications prescribed for the care of asthma. The student is be able to practice proper safety precautions for the handling and disposal of the equipment and medications that the student is authorized to use. Student misuse of medication being self-administered may result in seizure of medications and disciplinary action by the school.

☐ Student is **NOT ALLOWED** to self-carry, use and self-administer medication/s and will require assistance by authorized trained school personnel.

Physician/Healthcare Provider Printed Name: _____

Physician/ Healthcare Provider Signature: _____ Date: _____

Telephone Number: _____ Fax Number: _____

Reviewed by School Nurse Date: _____ Signature: _____

Revised 4/2/18, 4/12/18, 5/10/18, 8/12/18, 5/4/20
Policy: JLCD Administering Medications to Students