



ASTHMA CARE AT SCHOOL

April 2022

Dear Parents/Guardians,

If you and your student's medical provider believe your **high school or middle school student** is competent in recognizing his/her asthma symptoms and in the use of an inhaler, please provide the "**Medication Authorization and Contract to Self-Carry/Self-Administer Emergency Medication**" (attached). This will allow your student to manage, carry and administer his/her inhaler while at school. This form needs to be signed by a medical provider, a parent and the student.

It is strongly recommended that a back-up inhaler be available in the health office for students with a self-carry contract on file.

OR

If your student is an **Elementary student OR a secondary student who is not able to manage his/her own asthma**, your student's inhaler will need to be kept in the health office. Please provide the "**Colorado Asthma Care Plan and Medication Order**" (attached). This will allow staff to intervene and administer or help to administer the inhaler in an emergency. This form needs to be filled out and signed by a medical provider and a parent.

Please submit all forms to the school health office before the start of the school year. These forms need to be renewed yearly.

Please feel free to reach out for questions or to provide any other pertinent information about your child's asthma care to the Health Technician at your student's school or to the Elizabeth School District Nurse 303-646-6730.

Sincerely,

Lori Clark RN/BSN Elizabeth School District Nurse

Page 2: Medication Authorization and Contract to Self-Carry/Self-Administer Emergency Medication for Asthma and/or Anaphylaxis (HIGH SCHOOL/ MIDDLE SCHOOL STUDENTS ONLY)

Page 3: Colorado Asthma Care Plan and Medication Order



MEDICATION AUTHORIZATION AND CONTRACT TO SELF-CARRY/SELF-ADMINISTER EMERGENCY MEDICATION FOR ASTHMA AND/OR ANAPHYLAXIS
20 ____ - 20 ____

Student Name: _____ DOB: _____ School: _____

FOR MEDICAL PROVIDER

Medication: _____ Dose: _____ Route: _____

Time/Frequency: _____ Purpose: _____

Possible Side Effects: _____

Through my consultation with the above-named student's parent(s)/guardian(s), as well as my own assessment of this student, I have determined that they are able to identify their correct medication, demonstrate correct self-administration of the above listed medication, and has knowledge of the required dosage and timing/frequency of use of the medication. The Student has been instructed in the purpose, appropriate method, and frequency of use of the medication and is capable of self-administering the medication. A new form must be completed for all medication changes.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

FOR PARENT(S)/GUARDIAN(S)

The Parent(s)/guardian(s) agree(s) to:

- Assure that my/our child, the above referenced Student, will carry their Medication as prescribed, and that the device containing the medication and provided to the above referenced school is appropriately labeled by a pharmacist or healthcare provider and contains medication that has not expired;
- Review the medical provider's order(s)/instruction(s) for the medication on a regular basis; and
- Provide additional medication to the health office for the above referenced school for emergencies at their discretion.

It is understood that the Medication will be self-administered solely at the request of, and as an accommodation to, the undersigned parent(s)/guardian(s). In return for the authorization for my/our child to possess and self-administer medication at school, the undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my/our child or I/we sustain from my/our child's possession and self-administration of medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Phone Number: _____

FOR STUDENT

The Student agrees to:

- Be responsible for possessing and self-administering their medication at school and school-sponsored events and use it in a responsible manner as instructed by the above referenced medical provider;
- Notify a staff member if they need assistance or if they have used an emergency medication (e.g. epinephrine, inhaler, etc.);
- Not allow any other student to administer their medication to themselves and understand that if they do, they will be appropriately disciplined in accordance with the Elizabeth School District's Student Code and Discipline; and
- Understand that failure to comply with this contract and applicable school board policy will result in the loss of privilege to possess and self-administer this medication.

Student Signature: _____ Date: _____

FOR DISTRICT NURSE

The District Nurse agrees to:

- Will meet with the student to verify the student's technique in self-administering the Medication and to check for understanding of the medical provider's order(s)/instruction(s);
- Notify appropriate school staff of student's condition and student's authorization to possess and self-administer their Medication; and
- Maintain appropriate records associated with the student's possession and self-administration of the Medication.

District Nurse Signature: _____ Date: _____

This document is for students who are self-carrying Medication to address their health concern(s) and is in effect for the current school year unless revoked by an authorized medical provider or if the Student fails to meet contingencies cited below.