

MEDICATION PACKET FOR STUDENTS WITH ASTHMA

Here is a helpful checklist...

- ☐ Schedule an appointment with your child's health care provider over the summer to update medications and/or obtain new prescriptions
- ☐ Ask physician to complete and sign the **Inhaler Self-carry** form-- if you want your child to carry an inhaler in his/her backpack
- ☐ Parent: Read and sign the **Medication letter**
- ☐ Parent: Complete the **Medical Release** form
- ☐ Parent: Read and sign the **Medication Authorization** form
- ☐ Bring paperwork to the clinic
- ☐ If you would like to store an inhaler in the clinic, please bring a new one with the pharmacy label attached.

Note: In accordance with OCPS policy, if a student is found with medication or unauthorized inhalers, epi-pens, supplies, etc., the items will be taken and the parent/guardian will need to come to school to pick up the items.



Dear Parent/Guardian:

Due to requirements placed on the schools by Florida Statutes Chapter 232.22 (2), the following policy regarding medications dispensed at Discovery Middle School must be enforced.

Periodically, parents/guardians and physicians request that the student take medications during school hours. Parents/guardians are encouraged to develop a schedule so that the necessity for taking medications at school will be minimized or eliminated.

All medications shall be delivered to the Health Room with the following information on the pharmacy container for prescription medications and in the factory sealed container for non-prescription medication:

- a. Name and purpose of medication
- b. Time the medication is to be given
- c. Specific instructions on the administration of the medication
- d. Physician name and phone number
- e. Pharmacy name and phone number
- f. Approximate duration of medication, i.e., end of school year/10 days, etc., and possible side effects are to be listed on the Medication Authorization form.

Parents/guardians **must** bring all medications in the most current labeled container. Parents/guardians will be required to fill out a Medication Authorization form before medication can be dispensed. **Notes from home will not be accepted as authorization for dispensing medication.** This applies to all prescription as well as non-prescription medication.

If there is no medication authorization form, the medication will not be dispensed. Any medication brought to school without a Medication Authorization form will be held by the School Nurse/Health Room Assistant and the parent contacted. For safety and security reasons, medications must be transported to and from school by the parent/guardian. **Do not send medications to school with the child or siblings.**

Your cooperation in this policy is greatly appreciated. We know that you can appreciate the necessity of such a policy since it deals with the safety of our children receiving medication in our school.

Thank you,

Principal, Jeff Aldridge

Parent signature

Student Name

Form ID #
OCPS1100Stu



MEDICAL RELEASE FORM

Dear Healthcare Provider: _____ # _____
Name Telephone Number

In order to provide quality health services for: _____,
DOB: _____, at school, it is necessary to obtain a medical history and current
medical diagnosis, medications prescribed, physical limitations, nutritional needs and medical
orders for care at school. Records received will be placed in the student's health records in the
health room accessible to the parent/guardian (or designee), along with designated school
personnel.

Please forward all documents to:

Attention: Pam Furman BSN RN _____

School: Discovery Middle School _____

Address: 601 Woodbury Rd. _____

Orlando, FL 32828 _____

Phone: 407-384-1555 ext 5052278 _____

Fax: 407-384-1580 _____

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care
plans, immunization history, medical history and current medications) released to my child's
school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding
current/pending health issues.

Expiration Date: _____. If left blank, this Authorization expires one year from the date signed.

Parent/Guardian

Date

Home Phone Number

Work Phone

Cell Number



Teacher : _____ Grade: _____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to _____

School

To assist _____ DOB ____/____/____
Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask your pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS.** Notes from home will not be accepted as authorization for dispensing medication.

Signature of parent/guardian Date ____/____/____

() _____ () _____ () _____
Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.



Authorization for Self-Carry/Administration of Metered Dose Inhalers During and After School Activities

FS 409.9071 Section 232.47 states that an asthmatic student may be able to carry a metered dose inhaler on their person while in school when they have written approval from the parent/guardian and physician. The principal shall be provided with a copy of the parent/physician's approval.

Student: _____ DOB: _____ Grade: _____

School: _____

Medication: _____ Dose: _____ Time: _____

Method of Administration: Metered Dose Inhaler Spacer: (Y/N) _____

Diagnosis: _____

Possible Side Effects/Precautions/Recommended Interventions: _____

Duration (dates) of Administration: From: _____ To: _____ (Limit: One year).

I request that my child be allowed to carry/self-administer his/her medication and be responsible for its proper storage and use. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

Parent/Guardian _____ Date _____ Daytime phone number _____

I have demonstrated the correct use/administration of this medication and agree to terms of this contract. I will keep medication in agreed location, will not share medication with others, and will come to the Clinic/Health Room if my symptoms continue or worsen after using medication:

Symptoms: _____

Student _____ Date _____

I authorize this student to carry/self-administer the above medication. He/she has been trained to recognize signs and symptoms of asthma/breathing difficulties and how to correctly use the inhaler by me and/or my office staff.

Physician's Name/Stamp _____ Phone number _____

Physician's Signature _____ Date _____

☐ Extra inhaler in Health Room

☐ Original in Clinic/Health Room

☐ Copy to Student