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.

DISCOVERY MIDDLE SCHOOL
601 WOODBURY ROAD, ORLANDO, FLORIDA 32828
(407)384-1555 FAX: (407) 384-1580

PREVAILING IN EXCELLENCE
PROUD TO BE AN "A" SCHOOL

GLORIA E. FERNANDEZ, ED. D.
PRINCIPAL

Dear Parent/Guardian:

Due to requirements placed on the schools by Florida Statues 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. Parent/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 medication in the most current labeled container. Parents/guardians will be required to fill out a **Medication Authorization** form for each medication before medication(s) 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.

A medication authorization form must be on file at school for the medication to be dispensed. Any medication brought to school without a Medication Authorization form will be held by the School Nurse/School Health Assistant, and the parent will be contacted. For safety and security reasons, medications must be transported to and from school by a parent/guardian. **Do not send medication to school with the child or siblings.**

Your cooperation with this policy is greatly appreciated. We know that you can appreciate the necessity of such a policy to assure the safety of our children who are receiving medication in our school.

Thank you,

Principal

School Nurse

Parent Acknowledgement

Student Name (printed)

MEDICAL RELEASE FORM

Dear ______________________________________
(Physician)

____

____

Phone # ______________________________ Fax #____________________

In order to provide health services for: ___________________________, DOB: _________, it is necessary to obtain a medical history, immunization history, and a health plan including a list of current medications administered at home/school.

Please forward all documentation to:

Attn: School Nurse

School: OCPS-DISCOVERY MIDDLE SCHOOL

Address: 601 WOODBURY ROAD

ORLANDO, FL 32828

Phone: 407-384-1555 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 medications) released to my child's school to aid school personnel in service him/her.

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

__________________________________ ______________
Parent/Guardian Date

____________________ ____________________ ____________________
Home Phone Number Work Phone Cell Phone

Teacher :__________________ Grade:________

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Discovery Middle School
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: Aug 2019 To: Aug 2020 (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

Rev.08/01/11