

**FOX CHAPEL AREA SCHOOL DISTRICT**  
**INDIVIDUALIZED EMERGENCY HEALTH CARE PLAN**  
**ASTHMA**

Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ HR \_\_\_\_\_ School Year \_\_\_\_\_

**SIGNS OF MILD ASTHMA ATTACK**

Wheezing, coughing, chest tightness, shortness of breath during activity while at rest.

**SIGNS OF A SEVERE ASTHMA ATTACK**

Difficulty breathing, walking, talking, hunching over, lips or fingernails turn blue.

Chest and neck pulled or sucked in with each breath.

★ **EMERGENCY ACTION PLAN:**

1. If severe asthma attack is suspected, give \_\_\_\_\_  
(Medication/dose/route)  
and \_\_\_\_\_ **IMMEDIATELY!**

2. **CALL 911 (Activate EMS) IMMEDIATELY!**

3. **Notify Parent/Guardian**

**INHALERS and NEBULIZERS**

Inhalers, nebulizers and necessary medication are to be provided by parent and will be kept:

\_\_\_\_ Nurse's office      Date submitted: \_\_\_\_\_

\_\_\_\_ Student will carry inhaler with him/her at all times

-Specific Designated area: \_\_\_\_\_

-Student must agree not to remove inhaler for **any reason** (other than usage)

\_\_\_\_ Other: \_\_\_\_\_

**SELF ADMINISTRATION OF INHALER**

Does child self administer inhaler    Yes \_\_\_\*    No \_\_\_

\*If yes, student must:

-Understand circumstances/symptoms associated with their need for inhaler

-Know proper technique of self administration of inhaler

-Agree **NEVER** to share inhaler with another student

-Agree to seek help if severe asthma attack occurs

**FIELD TRIPS**

Necessary arrangements needed on field trips:

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Please address any other guidelines or special precautions that you feel is important to child's safety and care during the school day. Please be very specific:

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My signature indicates that I have completed the above information and agree with the recommended actions. I also authorize the release of this Individualized Health Care Plan to the employees of Fox Chapel Area School District.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



**PARENT/GUARDIAN  
REQUEST TO ADMINISTER MEDICATION IN SCHOOL**

Name	Grade	Room	School
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Please administer prescribed medication to our child according the Physician Medication Instructions.

As a parent/guardian of \_\_\_\_\_, we hereby release the Fox Chapel Area School District and all its employees from all liability for damages our child may suffer as a result of this request.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

**PHYSICIAN'S MEDICATION INSTRUCTIONS**

The parent/guardian has requested that medication be administered during the school day. If you feel it essential that the medications(s) be administered during the school day, we require completion of the information below.

Diagnosis \_\_\_\_\_

Medication	Dosage	Administration	Time
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Medication	Dosage	Administration	Time
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Self-administration with adult supervision:      Yes \_\_\_\_\_      No \_\_\_\_\_

Possible side effects \_\_\_\_\_

Curtailment of school activity (sports, shop, labs, driver's ed., etc.) \_\_\_\_\_

Duration:      From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month      Day      Year      Month      Day      Year

Other medications student is taking outside school hours \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number

**FOX CHAPEL AREA SCHOOL DISTRICT**  
**GUIDELINES FOR ADMINISTERING MEDICATION**

Medication should be given at home. Should the need arise for a student to be given medication during school hours, these procedures must be followed:

1. Written instructions signed by a physician with the diagnosis, medication, dosage, length of time to be given, possible side effects, and parent signature is required for all types of medication. Forms are available from the Certified School Nurse.
2. It is the parent's responsibility to maintain an adequate supply of medication throughout the school year.
3. **Medications must be brought to the School Nurse by the parent/guardian in the prescription-labeled container that must remain at school.**
4. If the School Nurse is not available, the building Principal or Acting Principal will accept and sign for medication.
5. Over-the-counter medication such as Advil, Tylenol, cough drops, will not be administered to Kindergarten- 8th grade unless prescribed by a physician.
6. The Certified School Nurse will review all new medication requests.
7. The first dose of a new medication: *It is the parent's responsibility to give the first dose when the child is able to stay at home to ascertain the child's reaction to the medication.*
8. Medications will be discarded one week following termination date or conclusion of the school year, unless return is requested by the parent. **Medication will be returned to the parent or an adult designee only.**

Field Trip Medication

1. Children with serious, life threatening or potentially life threatening medical conditions may request that medications be given on a field trip. No other medication will be permitted. Any parent who has a child needing medication in such a situation should contact the Certified School Nurse.

*NOTE: According to the American Academy of Pediatrics, life threatening conditions may include but are not limited to, conditions such as: Asthma, diabetes, seizure disorders, hormonal disorders or severe allergy.*

2. Parents of students who receive routine medication during school hours may choose to have the child not receive his/her medication on the day of the field trip. Otherwise, the parent may accompany the child on the field trip or make other arrangements with the Principal.

**NO MEDICATION WILL BE ADMINISTERED AT SCHOOL UNLESS ALL REQUIREMENTS OF THE MEDICATION POLICY ARE MET**