STUDENTS

Administration of Asthma Medications to Students

The school principal, as stated in the Code of Virginia §22.1-274.2 and §8.01-226.5:1, shall permit a student with a diagnosis of asthma to possess and self-administer inhaled asthma medications during the school day, at school-sponsored activities, or while on a school bus or other school property provided the following conditions have been satisfied:

I. A written authorization by a licensed physician or licensed nurse practitioner that the student has a diagnosis of asthma and has approval to self-administer asthma medications prescribed or authorized for the student by the physician or nurse practitioner.

II. The written authorization shall include:

   A. The student's name.
   B. The student's date of birth.
   C. The purpose of the medication.
   D. The name of the medication.
   E. The exact dose to be given at school.
   F. Exact condition or symptoms for repeating the medication.
   G. Special instructions as needed.
   H. Date of authorization, physician's name, signature, and telephone number.

III. The written authorization shall include verification by the physician or nurse practitioner of the student's demonstrated ability to safely and effectively self-administer inhaled asthma medications, and of the student's understanding that he/she is to report to the principal or his/her designee if self-administration of the medication as prescribed does not relieve the student's asthmatic symptoms.

IV. It is recommended that students in grades K-5 keep their medication in the designated area where they can be observed while the medication is being administered.

V. The written authorization shall also include guidance as to when the inhaled asthma medications may be used, such as before exercising or engaging in physical activity to prevent the onset of asthmatic symptoms or to alleviate asthmatic symptoms after the onset of an asthmatic episode.

VI. Should it be necessary for the physician to make any adjustments in the Asthma Action Plan, the building administrator and Supervisor of School Health Services shall be advised of such in writing from the parent/guardian. A new Asthma Action Plan must be

completed and signed by the physician and parent/guardian. All changes shall be subject to approval and shall adhere to the procedures outlines in this regulation. Upon approval, the school personnel responsible for the Asthma Action Plan shall then be instructed on all changes.

VII. The Asthma Action Plan must include the parent/guardian's written permission for staff to provide emergency treatment to the child.

VIII. Medication must be in the original container with a prescription label attached.

IX. The principal/designee shall consult with the student's parent/guardian before any limitations or restrictions are imposed upon a student's possession and self-administration of inhaled asthma medications, and before the permission to possess and self-administer inhaled asthma medications is revoked at any point during the school year.

X. A written release shall be required from the parent/guardian that acknowledges civil immunity for school boards and school employees who supervise self-administration of inhaled asthma medications by students (Attachment II).

XI. Disclosure or dissemination of information pertaining to the health condition of a student to school board employees should comply with Code of Virginia §22.1-287 and §22.1-289 and the federal Family Education Rights and Privacy Act of 1974, as amended, 20 USC §1232g, which govern the disclosure and dissemination of information contained in student records.

XII. The permission granted a student with a diagnosis of asthma to possess and self-administer inhaled asthma medications shall be effective for one school year and must be renewed annually.

XIII. Even if medication is not administered during the school day, it is recommended that all students with a diagnosis of asthma provide a Student Asthma/Action Plan (Attachment I) to the school. The Student Asthma/Action Plan provides vital information in the event of an emergency due to asthma or other allergies.

The principal and Director of the Office of Student Services are responsible for monitoring and implementing this regulation.

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for reviewing this regulation in 2010.

References:

VDOH/VDOE "Guidelines for Specialized Healthcare Procedures" (Revision 2004)

CINCH/Virginia Asthma Coalition – Asthma Health Care Action Plan and Authorization for Medication (Revision 3/07)

Legal Reference:

Code of Virginia §22.1-274.2, §8.01-226.5:1, §54.1-3408, §22.1-287, and §22.1-289.
20 USC §1232g

ASTHMA ACTION PLAN & AUTHORIZATION FOR MEDICATION

Attachment I
Regulation 757-5

TO BE COMPLETED BY PARENT:

Child's Name ______________ Date of Birth ______________ School ______________ Grade ______

Parent/Caregiver ______________ Phone (H) ______________ Phone (W) ______________ Phone (Cell) ______________

Address ______________ City ______________ Zip ______________

Emergency Contact ______________ Relationship ______________ Phone ______________

Name of Physician/Nurse Practitioner/Physician Assistant ______________ Office Phone ( ) Office Fax ( )

What triggers your child's asthma attack: (Check all that apply)

☐ Illness	☐ Cigarette or other smoke	Food ______________
☐ Emotions	☐ Exercise/physical activity	Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen
☐ Weather changes	☐ Chemical odors	☐ Other ______________

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

☐ Cough	☐ Tightness in chest	☐ Rubbing chin/neck
☐ Shortness of breath	☐ Breathing hard/fast	☐ Feeling tired/weak
☐ Wheezing	☐ Runny nose	☐ Other ______________

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The child's asthma is: ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent** ☐ **Exercise-Induced**

Symptoms **OR**	**Peak Flow Monitoring**	**Treatment**		
WELL • Usual medications control asthma • No cough or wheeze • Able to sleep through the night • No rescue meds needed • No activity restrictions (PE & recess are okay)	**GREEN ZONE** **Personal Best =** _______ _______ to _______	**Controllers & Relievers**	**How much**	**When**
		☐ Inhaled Corticosteroid ________		
		☐ Advair		
		☐-Symbicort		
		☐ Other ______________		
		Leukotriene Modifier: Singulair		
		☐ Other______________		
		Relievers		
		☐ Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	☐ **2 puffs or 1 nebulizer treatment 5 min. before physical activity**
		☐ Other______________		
		Other______________		
SICK • Needs reliever medications more often • Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities	**YELLOW ZONE** _____ to ____	1. ☐ Continue daily controller medications 2. ☐ Give albuterol 2-6 puffs (1 min. between puffs) with spacer or 1 nebulizer treatment, wait 20 min. 3. ☐ If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 min. **Call parent and/or MD.** **<u>If no improvement, CALL 911</u>** **If child returns to Green Zone:** ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ No physical exercise ☐ Physical exercise as tolerated i.e. PE & recess at school		
EMERGENCY! • Reliever medications do not help • Very short of breath • Constant cough	**RED ZONE** <________	☐**Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.** **<u>If there is no improvement, call parent and/or 911.</u>** **<u>Call 911 immediately if:</u>** • Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing		

PATIENT/STUDENT INSTRUCTIONS:

☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school
☐ Student is to notify his/her designated school health officials after using inhaler per school protocol
☐ Student needs supervision or assistance to use his/her inhaler ☐ Student shall **NOT** be able to carry his/her inhaler while at school

______________ ______________ __________ ☐**Valid for current school year**

HEALTH CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER'S NAME** **DATE**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

______________ __________

PARENT SIGNATURE **DATE**

cc: principal____ office staff____ librarian____ cafeteria mgr.____ bus driver/transportation____ Coach/PE____ teachers____

CINCH
Virginia Asthma Coalition
revision 3/07

Attachment II
Regulation 757-5

RELEASE AND ACKNOWLEDGEMENT AGREEMENT BY PARENTS OF CIVIL IMMUNITY FOR SCHOOL BOARDS AND SCHOOL EMPLOYEES

I/WE UNDERSTAND THAT the Code of Virginia §8.01-226.5:1 grants civil immunity for school boards and school employees who, in good faith, without compensation, supervise the self-administration of inhaled asthma medications by a student. The Prince William County School Board and Prince William County school employees shall not be liable for any civil damages for acts or omissions resulting from supervising the self-administration of inhaled asthma medications by students.

IT IS FURTHER AGREED AND UNDERSTOOD that it is my/our responsibility to ensure that the medicine is properly labeled as to its nature and the means of administration. It is also my/our responsibility to ensure that the medicine is fresh and adequately stored, and that an adequate supply is available at school. If the dosage changes or the medication is to be stopped prior to the time noted in the prescription, it is my/our responsibility to communicate the change clearly, in writing, to school staff.

I/WE CONSENT to the above conditions and acknowledge that Prince William County Public Schools is acting as my/our agent in supervising self-administration of asthma medication by my/our child.

I/WE FURTHER STATE that this release and acknowledgement agreement has been carefully read and I/WE know of the contents thereof and have signed the same by my/our own free act.

CAUTION: READ BEFORE SIGNING BELOW

Medication requested to be self-administered:____

____________________________	______________________________________
Name of Parent/Guardian (Printed)	Signature of Parent/Guardian
____________________________	______________________________________
Child's Name (Printed)	Date

(This agreement must be signed and returned to the building principal before medication can be administered.)