

AUBURN UNION SCHOOL DISTRICT

Parent Consent and Healthcare Provider Authorization For Management of Asthma at School Individualized School Healthcare Plan (ISHP)

Date _____

| | | |
|--------------|------------|-------|
| Student Name | Birth Date | Grade |
|--------------|------------|-------|

| | | |
|---------|------------|------------|
| Address | Home Phone | Work Phone |
|---------|------------|------------|

PARENT CONSENT

I(We), the undersigned, the parent(s)/guardians of the above named pupil, request the following for the Management of Asthma in school be administered to my(our) child in accordance with the California Education Code 49423.5.

I will: 1. Provide all medications, supplies, and equipment.

2. Notify the school nurse if there is a change in the pupil's health status or attending physician.

3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school nurse to communicate with the authorized health Care provider when necessary in regards to this specific medication and medical condition. I will be provided with a copy of my child's completed ISHP.

Parent/Guardian Signature _____ DATE _____

Healthcare Provider Authorization For the Administration of Medication by School Personnel

1. Medication: _____

2. Diagnosis: _____

3. Dose: _____

4. Method of Administration: _____

5. Time medication is to be given at school: (If appropriate please provide a range i.e. q.2- 4 hrs)

6. Symptoms for which drug is to be given _____

7. Possible reactions or side effects of medication: _____

(See next page for more instructions)

8. Student should respond to treatment in 15 – 20 minutes.
9. Seek emergency medical care if the student has any of the following
 - Coughs constantly
 - No improvement 15-20 minutes after initial treatment with medication and relative cannot be reached
 - Hard time breathing with
 - Chest and neck pulled in with breathing
 - Stooped body posture
 - Struggling or gasping
 - Trouble walking or talking
 - Stops playing and can't start activity again
 - Lips or fingernails are gray or blue

AUTHORIZED CONSENT FOR MANAGEMENT OF ASTHMA AT SCHOOL

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

1. I have instructed _____ in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by him/herself.
2. It is my professional opinion that _____ **should not** carry or administer his/her medication by him/herself.

Physician's Signature: _____ **DATE** _____

Address: _____ **Telephone:** _____

Principal's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____