Clarkson Public Schools

Self-Management of Asthma And Severe Allergy (Anaphylaxis) at School

PARENT/GUARDIAN: By signing below, you are acknowledging the following:

1. You are requesting that your child be allowed to self-manage his/her asthma or allergy condition at school.
2. You are affirming your confidence that your child has the knowledge and skills needed to self-manage his/her asthma or allergy safely at school.
3. You will provide a current, written asthma or anaphylaxis care plan to the school. We request you use the Clarkson Public School provided action plans from the American Lung Association, or provide complete and equivalent information.
4. If your child injures school personnel or another student as the result of misuse of necessary asthma or allergy supplies, you shall be responsible for any and all costs associated with such injury.
5. The school and its employees and agents are not liable for any injury or death arising from a student's self-management of his or her asthma or allergy condition.
6. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his/her asthma or allergy.

STUDENT: By signing below, you agree that you understand all of the above and:

1. You must not share, or allow anyone to handle your medications or supplies.
2. If you use your medication(s) you WILL notify a teacher, nurse or administrator that you have used your medication.

Parent/Guardian Printed Name	Student Name (printed)
Parent/Guardian Signature Date	Student Signature Date

NOTE: This applies only to the current school year or until rescinded by any party, whichever occurs first.

PHYSICIAN AUTHORIZATION must be received in writing, specifically indicating the student is authorized to self-manage his/her condition at school, according to the current medical management plan as described in the completed Asthma or Anaphylaxis Action Plan, accompanied by medical order for necessary medications and treatment.

Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/healthcare provider _____ Phone numbers _____
- Physician signature _____ Date _____

Severity Classification

- ❍ Intermittent ❍ Moderate Persistent
- ❍ Mild Persistent ❍ Severe Persistent

Triggers

- ❍ Colds ❍ Smoke ❍ Weather
- ❍ Exercise ❍ Dust ❍ Air Pollution
- ❍ Animals ❍ Food
- ❍ Other _____

Exercise

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days.
- ❍ Change your long-term control medicine by _____
- ❍ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief treatment again.
- ❍ Change your long-term control medicine by _____
- ❍ Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

- ❍ Still in the red zone after 15 minutes.
- ❍ You have not been able to reach your physician/healthcare provider for help.
- ❍ _____

Call an ambulance immediately if the following danger signs are present:

- ❍ Trouble walking/talking due to shortness of breath.
- ❍ Lips or fingernails are blue.

Rev. July 2008

Clarkson Public Schools
Request to provide acetaminophen and ibuprofen

IMPORTANT INFORMATION FOR PARENT/GUARDIAN: Your written consent is required before your child may receive these medications at school. Please complete this entire form. By signing below you acknowledge the following:

- You have reviewed the information and agree that your child may safely take the medication(s) in the manufacturer recommended dose. Any dose different then the recommended dose will need a physician's authorization.
- If the child has a fever of 100 degrees Fahrenheit or greater, or if the child is suspected of being ill, the parent will be notified and the child will be sent home.
- Your child's medication may be administered by a nurse or by other school personnel determined competent to provide medication as required by Nebraska Law.
- This service is intended to help your child's performance during the instructional period.

PARENTAL CONSENT

I give my permission to Clarkson Public Schools to administer the following medications, according to approved dispensing guidelines, for a mild headache or mild discomfort to:

_____ _____

Child's Name (please print) Date of Birth

Please check if approved.

Acetaminophen (generic Tylenol)_____ Ibuprofen (generic Advil/Motrin)_____

Reason for medication: _____

Please complete the following:

My child has taken the acetaminophen before without a problem. YES _____ NO _____

My child has taken ibuprofen before without a problem. YES _____ NO _____

Please notify me before my child takes medicine. YES _____ NO _____

Contact Name and phone number: _____

My child is taking other medications at this time. YES _____(please list below) NO _____

Medication(s) currently taking and reason for the medication: _____

_____

Special instructions concerning my child:_____

_____ _____

Signature of parent/guardian Date

CLARKSON PUBLIC SCHOOLS
EMERGENCY/CONTACT FORM

(Please indicate the appropriate information for each student in the family)

Student Name Sex Social Security Number Student Age/Birth Date Grade

_____

_____

_____

_____

Mailing Address (P.O. Box or 911 Address):

_____

_____

Telephone: _____

Cell Number: _____

Ride Bus: Yes (Bus No. ____) or No

May we contact you by e-mail for grades, lunch account, and general pertinent school information? Yes or No

E-mail Address: _____

(WHERE TO REACH PARENTS IF NOT AT HOME – PLACE OF WORK)

Mother Work

Name: _____ Place: _____ Phone: _____

Father Work

Name: _____ Place: _____ Phone: _____

(PERSONS TO CONTACT IF SCHOOL IS UNABLE TO REACH PARENTS)

Name: _____ Phone: _____

Name: _____ Phone: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Physician: _____ Phone: _____

Due to section 504 of the Rehabilitation Act of 1973, the State of Nebraska requires all schools to identify every student who is susceptible to life threatening reactions (Asthma $ Anaphylaxis). We need a brief medical history of your child(ren) to ensure all academic needs are met in the general education classroom. In order to better serve our student population we would like you to voluntarily fill out any other information relating to your student's health and health history (i.e. heart murmurs, organ replacement, migraines, etc.) All information will be kept confidential within the school system. Please list information for each of your students.

Medical Conditions

Does your child have any known medical conditions? (anything that limits walking, seeing, hearing, speaking, breathing, learning, or working that has been diagnosed by a doctor)? Please include allergies.

_____ YES _____ NO

If yes, please describe, including triggers, signs, or symptoms Please list student's name by their medical condition.

_____

_____

_____

Treatment Plan – Describe the steps to be taken for treatment.

_____

_____

_____

Parent's Signature:_____

RECEIPT OF STUDENT HANDBOOK
I have read and understand the regulations outlined in the student handbook. I understand that should there ever be a question about compliance with a regulation, I may contact the principal or superintendent to discuss the matter.

_____ signature of parent/guardian

_____ signature of student(s)

CLARKSON GUIDANCE PROGRAM
I give my children permission to participate in the Clarkson Guidance Program.

_____ signature of parent/guardian

USE OF STUDENT NAME OR PICTURE
I give permission to post a picture which may include my child on the CPS webpage and newsletter (full name may be posted with pictures).

_____ signature of parent/guardian

PERMISSION FORM
I give my children permission to participate in field trips, activity trips, and other school related trips. I understand I or my children will receive information about each of these trips. I understand that school provided transportation will be provided. I understand that the students will NOT always be under the direct supervision of a teacher or another adult while on these trips, I understand the inherent risks involved in these activities.

_____ signature of parent/guardian

Kindergarten-6 Grade Students

ACCEPTABLE USE OF COMPUTERS, TECHNOLOGY, AND THE INTERNET
I give permission for my child/children to use technology equipment (i.e. laptop computers, Ipads), and said child/children in grades Kindergarten through six agree to abide by the district's guidelines regarding digital citizenship and internet usage as referenced on pages 16-17 of this handbook.

_____ signature of parent/guardian

7-12 Grade Students

PERMISSION FORM
I give my children permission to help or volunteer with activities such as moving chairs, tables, setting up activities, such as games, concerts, etc. and unloading commodity trucks. No students will be asked to leave town without getting parental approval.

_____ signature of parent/guardian

Please return pages 38 - 43
to the office by Friday, August 28th.
Thank you.