Student Health, Wellness & Prevention
Parent Consent and Healthcare Provider Authorization
For Management of Asthma at School
Individualized School Healthcare Plan (ISHP)

Student Name Birthdate 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. Diagnosis:_____
2. Medication:_____
3. Dose: _____
4. Method of Administration: _____
5. Time medication is to be given at school: (If appropriate please provide a range eg.. q.2- 4 hrs)

   _____
6. Symptoms for which drug is to be given_____
7. Possible reactions or side effects of medication: _____

   _____

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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 any of the following:
    - Chest and neck pulled in with breathing
    - Stooped body posture
    - Struggling or gasping
- Trouble walking or talking
- Stops playing and can't restart or regain activity
- 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).

☐ I have instructed student 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.

☐ It is my professional opinion that student **should not** self-carry or self-administer his/her medication.

☐ Student should be supervised in administering medication, but MAY SELF-CARRY medication.

Physician's Signature:_____DATE_____

Address:_____Telephone: _____

School Nurse's Signature:_____Date: _____