Dear Parents/Guardians:

Prescription medications and over the counter (OTC) medications may not be dispensed by school officials until the following guidelines have been met, and the paper work received.

Physicians are encouraged to schedule doses of medication around school schedules so that it will not be necessary for the school district to be placed in the business of dispensing medications. Medication administration is normally not a function of education but if it becomes necessary for a student to take medication/treatment at school then the following guidelines must be followed:

1. Provide building principal (nurse) with completed medication forms signed and dated by physician and the parent/guardian.
2. Prescription medication must be brought to school in the container in which it was purchased. The label must include student's name, medication name/dosage, administration route/any other directions, address, phone number, name or initials of pharmacist.
3. Over the counter medication (OTC) or non-prescription medication must be received in the original container in which it was purchased. The student name must be affixed to the container as well as the date sent.
4. No medication, whether prescribed or over the counter, may be given to a student without a physician's order as well as signed parental authorization and permission according to school code, and state law.
5. No medication, whether prescribed or over the counter, may be carried by a student unless the physician has ordered the medication to be self-administered and carried by the student and the proper medication and permission forms have been completed and signed.
6. The school does not assume responsibility for medication, which is not delivered to and kept in the school office or other secure designated area.
7. Parents must notify school of medication/treatment changes or discontinuation.
8. This request must be renewed annually.
9. Students that are able to carry and self-administer their inhaler may have a completed parental authorization form in place of a physician's order. The prescription label must be attached to the inhaler or the inhaler must be in the box with attached prescription label.

Parental Authorization for Self-administration of Quick Reliever Asthma Inhaler

I hereby authorize Sherrard CUSD #200 and its employees and agents, on my behalf and stead, to allow my child,_____, to carry and self administer her/his quick reliever asthma inhaler following instructions outlined on the prescription label.

I further acknowledge and agree that, when the lawfully prescribed medication is so self-administered or attempted to be self-administered, I waive any claims I might have against the School District, its employees and agents arising out of the self-administration of said medication.

In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the self-administration or attempts at self-administration of said medication.

Parent's Signature_____Date_____

Phone_____Cell Phone_____Work Phone_____

Parent Address_____

Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Before exercise	❒ _____	❒ 2 or ❒ 4 puffs _____	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

First

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

_____ ❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour
(short-acting $beta_2$-agonist) ❒ Nebulizer, once

Second

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
❒ Take: _____ ❒ 2 or ❒ 4 puffs or ❒ Nebulizer
(short-acting $beta_2$-agonist)
❒ Add: _____ mg per day For _____(3–10) days
(oral steroid)
❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

❒ _____ ❒ 4 or ❒ 6 puffs or ❒ Nebulizer
(short-acting $beta_2$-agonist)

❒ _____ mg
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ NOW!**
(phone)

See the reverse side for things you can do to avoid your asthma triggers.

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

❒ Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

❒ Dust Mites

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130º F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

❒ Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

❒ Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

❒ Pollen and Outdoor Mold

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

❒ Tobacco Smoke

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

❒ Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

❒ Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

❒ Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

U.S. Department of Health and Human Services
National Institutes of Health

National Heart Lung and Blood Institute

For More Information, go to: www.nhlbi.nih.gov

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SHERRARD COMMUNITY UNIT SCHOOL DISTRICT #200
REQUEST FOR THE ADMINISTRATION OF MEDICINE OR TREATMENT

Student's Name_____ Grade/Teacher_____

Parent/Guardian's Name_____Emergency phone #_____

Physician's Request for Administering Medication at School/School Events

Medicine or Treatment_____ Diagnosis_____

Dosage and directions for administration at school/school events_____
_____Discontinuation Date_____

Possible Side Effects_____

May child self-administer this medication at school under supervision of Health Service personnel or designate _____? (If yes, the attached student self-administration form must be completed.)

Physician's signature and stamp_____

Physician's phone number_____ Date Signed_____

Parent's Request for Administering Medication at School/School Events
Parental Authorization:

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Sherrard School District #200 and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child, _____(or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the Sherrard School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the school District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent's Signature_____ Date_____
Home Phone_____ Work Phone_____
Parent's address_____

Parent Agreement for Child to Carry Medication/ Treatment Devices

Sherrard CUSD #200

Sherrard Senior High School
Sherrard Junior High School
Matherville Intermediate School
Sherrard Grade School
Winola Elementary Grade School

I give permission for my child _____ to carry the medication(s)/treatment devices described below. I will notify the school of changes in medication or my child's condition.

Name of Medication/Treatment	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature_____

Date_____

Self-Administration of Medication or Treatment
Sherrard CUSD #200

Dear Parent/Guardian:

State law requires that we inform the parents or guardians of the student, in writing, that the school district and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or treatment by the student.

The permission for self-administration of medication/treatment is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student with _____ may possess and use
(Health Condition)
his/her medication/treatment device, while in school, at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before school or after-school care on school-operated property. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her medication.

We are requesting that you sign and return a copy of this document to school.

I _____ parent or guardian of
_____, acknowledge that Sherrard District #200 or
_____ school and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of _____ by the above named student. I indemnify and
(Name of medication/treatment)
hold harmless the Sherrard School District #200 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication/treatment by the student.

Parent signature_____
Date_____

Witness_____