

MANAGEMENT OF ASTHMA IN THE SCHOOL SETTING

On August 16, 2001, Public Act 92-0402 created in the School Code a new section entitled "Self-administration of Asthma Medication". The general requirement of the new law is that when certain conditions are met, a school must permit the self-administration of medication by a pupil with asthma. These conditions are as follows:

- ❖ The medication must pertain to the pupil's asthma and have an individual prescription label.
- ❖ The medication must be prescribed by a physician, physician assistant, or advance practice nurse having authority to prescribe such medication.
- ❖ The parents or guardian must provide the school with written authorization for self-administration of the medication. **Self-administration means that the pupil has the discretion as to the use of his or her medication.**
- ❖ The parents or guardian must also provide the school with a written statement from the pupil's physician stating the name and purpose of the medication, prescribed dosage, and time(s) at which special circumstances under which the medication is to be administered by pupil.

There are two options available for the child who needs to use an inhaler at school.

Option #1 The child will be allowed to carry his/her own inhaler and use it without supervision. To utilize this option, the Contract for Self-administration of Medication must be signed by student, parent, and physician and returned to the school to keep on file.

Option #2 The child comes to the nurse's office where the inhaler is kept, and uses it under supervision. To utilize this option, the Authorization for Administration of Medication at School must be signed by the parent and physician and returned to the school to keep on file.

If you have any questions or need any medication forms, please contact the school nurse @ 625-2231 ext. 203.

CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION

PAWNEE COMMUNITY UNIT SCHOOL DISTRICT #11

PHONE: 625-2231

FAX: 625-2251

STUDENT'S NAME _____

Grade _____ Date of Birth _____

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The following section is to be completed by the STUDENT:

I agree to never share my inhaler with another person and I will use it only as prescribed and instructed by my doctor. I will tell the teacher, school nurse, or other responsible adult if there is no improvement after using my inhaler as instructed.

Student's signature

Date

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The following section is to be completed by the PARENT:

I give my permission for _____ to carry the inhaler and self-administer the medication as described below. I understand that self-administer means that he/she has the discretion as to the use of the medication. By signing below I authorize the Pawnee School District and its employees and agents to allow my child or ward to possess and use his/her asthma medication while in school, at a school sponsored activity, and before or after normal school activities. The Pawnee School District and its employees and agents incur no liability, except for willful and wanton conduct, as a result of an injury arising from a student's self-administration of medication. I agree to indemnify and hold harmless the Pawnee School District and its employee and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child. (Legal reference 105 ILCS 5/22-30)

Parent/Guardian Signature

Date

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The following section is to be completed by the PHYSICIAN:

NAME OF MEDICATION _____

DOSAGE _____ INSTRUCTIONS FOR USE/FREQUENCY _____

DIAGNOSIS for which medication is intended _____

EXPECTED SIDE EFFECTS _____

*****Please provide additional information for the child's asthma action plan at school:**

KNOWN TRIGGERS _____

PEAK FLOW RANGE _____

SPECIAL INSTRUCTIONS _____

I certify that the above name pupil has been instructed in the use of self-administration of the above named medication. He/She understands the need for medication and necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

*valid for 2006-07 school year

Physician Signature

Date

Phone

Fax