

ROCKLIN ACADEMY

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

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

3. Notify the school 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 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. 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: _____