Upper Moreland Township School District

Dear Parent/Guardian of: ______________________________

Any student with a diagnosis of:

- SEVERE FOOD ALLERGY, ______
- SEVERE INSECT ALLERGY ______
- ASTHMA ______
- DIABETES ______
- SEVERE ALLERGY ______ unknown trigger

AND any student who may use one of the following medications while at school: **Oral antihistamines; Injectable Epinephrine; Inhalers; Nebulizer treatments,** **is required** to have an Action Plan on file in their students Health Record. Action Plans require **yearly updates**.

In order to ensure appropriate Medical Treatment for your child, please complete the attached Action Plan; have your Health Care Provider update the Medical Information and SIGN the form, (if available, your Health Care Provider may also use their own office Action Plan.)
Return the completed Action Plan to the School Nurse.

Thank you so much for your cooperation to this very important matter.

UMTSD Nursing team

DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Asthma Action Plan

(To be completed by Doctor/Nurse)

Name ____________ Birth Date ____________ Effective Date ____________

School ____________ Parent/Guardian ____________ Parent's Phone ____________

Doctor/Nurse's Name ____________ Doctor/Nurse's Office Phone ____________

Emergency Contact After Parent ____________ Contact Phone ____________

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other: ____________

TAKE THESE MEDICINES EVERYDAY

Green

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow in this area:

________ to ________

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

IF NOT FEELING WELL — TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

Yellow

Child has *any* of these:

- Cough
- Wheeze
- Tight Chest

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow in this area:

________ to ________

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After ______ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! — TAKE THESE MEDICINES

Red

Child has *any* of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow below:

____

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature ____________ Date ____________

Health Care Provider Signature ____________

One copy for the Health Care Provider, one copy for Parent, return color copy to the School Nurse.

Adapted from the NYC Childhood Asthma Initiative

Adapted from NHLBI

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SCHOOL DISRICT OF UPPER MORELAND TOWNSHIP
2900 TERWOOD ROAD
WILLOW GROVE, PA

USE OF MEDICATION PERMISSION FORM

The Board of School Directors of Upper Moreland Township, in accordance with the guidelines from the Pennsylvania Department of Education and Pennsylvania Department of Health, has revised Policy 210 and has adopted Policy 210.1 concerning the administration of medication in school. For the purposes of these policies, "Medication" includes Prescription and Over the Counter medicines. The policy states that all medication brought to school must be in the original labeled container and must be **delivered to school by the parent/guardian.** All medications are to be kept in the nurse's office unless otherwise specified by the child's Health Care Provider. Every attempt should be made to dispense medication at home; however, any medication deemed necessary for the continued treatment of medical conditions will be given during school hours as prescribed by the child's Health Care Provider.

Prescription Medication:
-A written/electronic Prescription from the child's Health Care Provider is required in order to dispense Prescription medication at school. This form can also be used by your Health Care Provider.
-All Prescription medication must be brought to school in the labeled Pharmacy container.

Over the Counter Medication:
-A written/electronic Prescription from your child's Health Care Provider is required in order to dispense Over the Counter medications at school. This form can also be used by your Health Care Provider.
-All Over the Counter medications supplied by parent/guardian must be brought to school in the labeled container.

ATTENTION PARENT/GUARDIAN: **Your signature and the signature of your Health Care Provider is required on the lower portion of this form.** By providing these signatures, you are giving permission for administration of medication to your child during school hours. Please fill in all sections to ensure that medication is given correctly.

School District of Upper Moreland Township
PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

Student Name ______________________________ Grade ____________

Name of Medication ______________________________ Dosage __________

(Inhalers, Epi-pens, Insulin pumps and Insulin injections require Action Plan or Treatment Plan attached for use in school)

Time to be Given ____________________ Length of Time ______________

Reason for Medication ____

Parent/Guardian Signature ____________________ Phone ______________ Date ________

Health Care Provider Signature ______________________________ Date ____________

Permission to carry Inhaler: yes no MD/DO/NP signature ______________________________

Permission to carry Epi-pen: yes no MD/DO/NP signature ______________________________

Permission for School Nurse to administer Over the Counter:
Acetaminophen yes no Ibuprofen yes no Antacid (9th-12th only) yes no

*** **PLEASE NOTE:** Physicians orders and Parent Permission are valid for the current school year and MUST be updated each year.