SAINT JOSEPH HIGH SCHOOL

# Asthma Health Plan

Student's Name: _____ Grade: _____

Student Lives With: _____ Date: _____

Parent/Guardian to call with questions:
Name: _____ Phone: _____

Allergies: _____

| | |
|---|---|
| Does your child have an inhaler prescribed for them? | ◻ Yes ◻ No<br>*If Yes, please be sure to fill out the required consent forms* |
| If yes, does your child take oral medications for their asthma? | ◻ Yes ◻ No<br>If yes, when do they take them?<br>_____ |
| Please list medications your child takes for asthma | 1._____<br>2._____ |
| Will your child carry an inhaler with them during the school day? | ◻ Yes ◻ No<br>If Yes, **see #1 for required form**<br>If No, **see #3 below, and please sign release** |
| Will your child keep an inhaler in the nurse's office? | ◻ Yes ◻ No<br>If Yes, **see #2 for required form**<br>If No, **see #3 below, and please sign release** |

**Please fill out the appropriate form based on how your child will handle their food allergy at school:**

1. If your child will carry an inhaler during the day, please fill out the following Physician Authorization for Self-Carry Emergency Medication in School
2. If your child will keep an inhaler in the nurse's office, please fill out the Parent Consent Formand the Physician Consent Form.
3. If your child **will not carry an inhaler or keep one in the nurse's office,** please fill out the Inhaler Release Form

**Please list all medications that your child takes, including over-the-counter:**

1. _____
2. _____
3. _____

**Please list any other pertinent medical history and surgeries, including any past concussions, with corresponding dates:**

1. _____
2. _____
3. _____

**Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety?**

_____

_____

**Does your child need the inhaler prior to exercise or exertion**? _____

Have you talked to your child about handling this at school and what is the plan for PE class?

_____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status.

Parent Signature: _____ Date: _____

**Please contact Katie Harshman RN, BSN with any questions.**
**kharshman@saintjoehigh.com**
**574-472-1245**

SAINT JOSEPH HIGH SCHOOL

**Written Consent for Administration of Medication- Parent/Guardian**

Student Name: _____ DOB: _____

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parent's consent, in writing, to the administration of medication. In order for the school nurse, volunteer, or staff member to administer medication to your student, the form below must be read and signed.

1. **Prescription Medication**: The school must have on record a written order from the prescribing physician/practitioner and a written consent form from the parent/guardian for prescription medication.
2. **Over-the- Counter Medication**: There must be a written request from the parent/guardian for Over the Counter (OTC) medications before they will be administered to a student at school.
    - Medications prescribed and/or OTC meds sent from home should be kept in the original container with the pharmacy or brand label affixed. The label must include the following:
        - Student's name
        - Name of Medication and
        - Dosage of Medication Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in at the nurse's office and kept in a locked cabinet.
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
5. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff cannot take a physician order over the phone.
7. Over-the-counter medication will be administered in a manner consistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

**I have read and understand the above policy.**

- Please administer to, _____, the medications (both prescription and/or OTC) as described below (*prescription medication also requires the Physician Consent):*

| Medication | Dosage | Time | Precautions |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Reason for Medication: _____

Period of time medication is to be continued:: _____

Parent Signature: _____ Date: _____

Printed Name: _____ Phone: _____

SAINT JOSEPH HIGH SCHOOL

## Written Consent for Administration of Medication- Physician

Student Name: _____ DOB: _____

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parent's consent, in writing, to the administration of medication. In order for the school nurse, volunteer, or staff member to administer medication to your student, the form below must be read and signed.

1. **Prescription Medication**: The school must have on record a written order from the prescribing physician/practitioner and a written consent form from the parent/guardian for prescription medication.
2. Medication brought to the school must be checked in at the nurse's office and kept in a locked cabinet.
3. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
4. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
5. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff cannot take a physician order over the phone.

**I have read and understand the above policy.**

- Please administer to, _____, the **prescribed** medication(s) written below, in accordance with the written order of the physician/practitioner (*requires physician and parent signature*):

| Medication | Dosage | Time | Precautions |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Reason for Medication: _____

Period of time medication is to be continued: _____

**Physician Signature**: _____ Date: _____

Printed Name: _____

**Parent Signature**: _____ Date: _____

**Please fax completed form to: 574-232-1158**

SAINT JOSEPH HIGH SCHOOL

# Inhaler Release Form

Student: _____ Grade: ____ Date of Birth: _____

My child _____, has a documented diagnosis of Asthma, but ***does not need*** to carry an inhaler with them or have one in the nurse's office at school.

Parent Signature: _____

Date: _____

SAINT JOSEPH HIGH SCHOOL

**2025-2026 School Year: Written Consent for Administration of Stock Medication- Parent/Guardian**

Student Name: _____ DOB: _____ Grade: _____

In order to protect the health and welfare of the students and school staff alike, Indiana laws require that parent's consent, in writing, to the administration of medication. In order for the school nurse, volunteer, or staff member to administer medication to your student, the form below must be read and signed.

1. **Prescription Medication**: The school must have on record a written order from the prescribing physician/practitioner and a written consent form from the parent/guardian for prescription medication.
2. **Over-the- Counter Medication**: There must be a written request from the parent/guardian for Over the Counter (OTC) medications before they will be administered to a student at school.
    - Medications prescribed and/or OTC meds sent from home should be kept in the original container with the pharmacy or brand label affixed. The label must include the following:
        - Student's name
        - Name of Medication and
        - Dosage of Medication Prescribing Physician/Practitioner (if applicable)
3. Medication brought to the school must be checked in at the nurse's office and kept in a locked cabinet.
4. The school nurse/assigned staff member must be aware of the purpose for which the student is receiving the medication.
5. In specific cases, the school nurse/assigned staff member may require the parent(s)/guardian to come to the school to administer the medication.
6. All prescribed medication will be administered strictly in accordance with the written order of the physician/practitioner. The dosage may be changed only if the school is provided with the written order of the physician/practitioner authorizing the change. The school secretary/staff cannot take a physician order over the phone.
7. Over-the-counter medication will be administered in a manner consistent with the instructions on the brand label, unless the school receives a written order of a physician/practitioner authorizing such administration.

**I have read and understand the above policy.**

- Please administer to, _____, the medications (both prescription and/or OTC) as described below (*prescription medication also requires the Physician Consent):*

| Medication | Dosage | Time | Special Instructions |
|---|---|---|---|
| 1. Ibuprofen | 200 mg tablets | **1-2 tablets every 4-6 hours** | |
| 2. ES Acetaminophen | 500 mg caplets | **1-2 caplets every 6 hours** | |
| 3. Cough Drops | Max of 3 per day | As needed | |
| 4. Tums (or generic) | 500mg Max of 3 per day | As needed | |

**Period of time medication is to be continued: 2025-2026 School Year**

Parent Signature: _____ Date: _____

Printed Name: _____ Phone: _____

DIOCESE OF
FORT WAYNE-SOUTH BEND
CATHOLIC SCHOOLS OFFICE

## Physician Authorization for Self-Carry Emergency Medication in School

I have diagnosed _____ (**student name**)
with_____ (**chronic disease**) for which emergency medication
_____(**name of medication**) may be needed while at school or during school-sponsored activities.

I have instructed this patient how to safely and appropriately use this medication and I believe that they are capable of using the medication as instructed. I believe that this patient should carry this medication and will use it in a responsible manner, in accordance with my orders and instructions.

**Physician Name:** _____**Physician Signature:** _____
**Date:** _____

**Student Responsibility:**

_____ I plan to keep my emergency medication with me at school rather than in the nurse's office.
_____ I agree to use my emergency medication in a responsible manner, in accordance with my physician's orders.
_____ I will notify the nurse if I use my emergency medication.
_____ I will not allow any other person to use my emergency medication.

**Student's signature:** _____ School Year: _____

**Parent Responsibility:**
This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.
_____ I agree to see that my child carry his/her medication as prescribed; that the device contains medication and the medication is not expired.
_____ It has been recommended to me that back-up medication be provided to the nurse's office for emergencies.
_____ I will review the status of the student's health condition on a regular basis.

**Parent Signature:** _____ Date: _____