Alabama School of Mathematics and Science

CHRONIC ILLNESS: PARENT /LEGAL GUARDIAN ACKNOWLEDGEMENT

STUDENT SELF-ADMINISTRATION
OF CHRONIC ILLNESS MEDICATION

I hereby affirm that my child_____ is currently enrolled at the Alabama School of Mathematics and Science (ASMS) and is currently being treated for a chronic illness (_____) under the care of a physician. (Chronic illness being defined as an illness being treated under a doctor's care for 3 months or longer.)

I also affirm that he/she has been instructed in the proper self-administration of the prescribed chronic illness medication by his/her attending physician. I agree with the plan written out by the physician concerning my child's chronic illness and medications listed on the Chronic Illness Medical Authorization form.

As his/her parent/legal guardian, I understand that the permission for the self-administration of chronic illness medication(s) shall only be effective for the school year in which the permission is given, and that permission may be granted in subsequent years for my child provided that the required forms are re-submitted each school year.

I understand that upon obtaining permission to self-administer the prescribed chronic illness medication(s), my child shall be permitted to possess and self-administer the prescribed medication(s) at any time while on school property or while attending a school-sponsored activity.

I also hereby acknowledge that as the parent/legal guardian of_____
I shall indemnify and hold harmless the school (ASMS), the agents of the school (ASMS), and the State of Alabama against any claims that may arise relating to my child's self-administration of approved medication(s).

_____ _____

Signature of parent/legal guardian *PRINTED name of parent/legal guardian*

PHONE NUMBER: _____ DATE: _____

Alabama School of Mathematics and Science

CHRONIC ILLNESS: MEDICAL AUTHORIZATION

(Physician to fill out)

STUDENT SELF-ADMINISTRATION OF CHRONIC ILLNESS MEDICATION
(Chronic illness being defined as an illness being treated under a doctor's care for 3 months or longer)

_____ is currently a patient under my care being treated for the chronic illness of _____. (Example: asthma, migraine, birth control, DM, glaucoma…but **NEVER** for ADHD or other conditions requiring controlled/abused medications or illness requiring frequent monitoring by school staff).

I hereby affirm that he/she has been instructed in the proper self-administration for the prescribed medication(s) listed below.

MEDICATION(s) name/dose/frequency/route:_____

_____

_____

THE LENGTH OF TIME for which the medication(s) is/are prescribed for: _____

SPECIAL INSTRUCTIONS OR CIRCUMSTANCES, IF ANY, UNDER WHICH THE MEDICATION(S) SHOULD BE ADMINISTERED BY SCHOOL STAFF: _____

_____

EMERGENCY PROTOCAL FOR THIS CHRONIC ILLNESS: (If asthma, see Asthma Action Plan)
• Symptoms that are considered an emergency: _____

• Recommended Treatment for emergency:_____

_____

In the case of adverse reaction to medication: _____

_____
Signature of attending physician or his/her authorized agent

_____
PRINTED name of attending physician or his/her agent

OFFICE ADDRESS:
_____
_____
_____
PHONE: (___)_____

DATE:_____

Alabama School of Math and Science

_____ ACTION PLAN
diagonisis for action plan

NAME: _____ **DOCTOR:** _____ **DOCTOR'S PHONE NUMBER:** _____ **PHONE NUMBER OF EMERGENCY CONTACT:** _____	1. **GREEN** means **GO**. Use preventative medicine. 2. **YELLOW** means **CAUTION**. Use quick relief medicine. 3. **RED** means **EMERGENCY**. Get help from a doctor.
1. Green—Go • Symptoms are minimal/none. • Can continue normal activities of daily living.	**Use Preventative Medicine (daily medication)** Medicine (Name/Dosage/Frequency/Route) _____ _____ Other instructions: _____ _____
2. Yellow—Caution • List symptoms for this section 1. 2. 3.	**Take Quick-Relief Medicine to keep an symptoms under control. (PRN medications)** Medicine (Name/Dosage/Frequency/Route): _____ _____ Other instructions: _____ _____
3. Red—Emergency • Symptoms not relieved by medication • Blue color to mouth/nails/ or skin • Difficulty speaking or walking • Unconscious • •	**GET HELP FROM A DOCTOR OR HOSPITAL!** Emergency Medicine: (Name/Dosage/Frequency/Route): _____ _____ ***CALL 911 stay with the child until EMS arrives*** **Call parent and school nurse **Monitor vital signs and give appropriate first aid until EMS arrives **Give emotional support to student Other instructions: _____ _____

I hereby affirm that this student has been instructed and understands the above measures listed in this Health Action Plan. I give my permission to the school nurse and other designated staff to perform the task as outlined in this plan. This information may be shared with school staff on a need to know basis.

_____ _____ _____
Physician's Signature Print Physician Name Date

_____ _____ _____
Parent's/Guardian's Signature Print Name Date

For School Only: Approval of plan of care: _____