

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 Math-	
ematics and Science (ASMS) and is currently being treated for physician. (Chronic illness being defined as an illness being to	a chronic illness () under the care of a	
I also affirm that he/she has been instructed in the proper self-orbits her attending physician. I agree with the plan written out medications listed on the Chronic Illness Medical Authorization	administration of the prescribed chronic illness medication by the physician concerning my child's chronic illness and	
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.		
Signature of parent/legal guardian	PRINTED name of parent/legal guardian	
PHONE NUMBER:	DATE:	



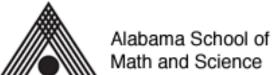
Alabama School of Mathematics and Science

CHRONIC ILLNESS: MEDICAL AUTHORIZATION

(Physician to fill out)

PHONE: (___)_____

(Chronic illness being defined as an illness being treat	
is currently	a patient under my care being treated for the chronic
illness of (Exam	nple: asthma, migraine, birth control, DM, glaucomabu
NEVER for ADHD or other conditions requiring contro	lled/abused medications or illness requiring frequent
monitoring by school staff).	
I hereby affirm that he/she has been instructed in the medication(s) listed below.	proper self-administration for the prescribed
MEDICATION(s) name/dose/frequency/route:	
SPECIAL INSTRUCTIONS OR CIRCUMSTANCES, II	s/are prescribed for:F ANY, UNDER WHICH THE MEDICATION(S) SHOULD
BE ADMINISTERED BY SCHOOL STAFF:	
EMERGENCY PROTOCAL FOR THIS CHRONIC ILL 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:	DATE:



ACTION PLAN

<i>,,,,,</i> • ,,,,,	
NAME:	GREEN means GO. Use preventative medicine.
DOCTOR:	·
DOCTOR'S PHONE NUMBER:	YELLOW means CAUTION. Use quick relief medicine.
PHONE NUMBER OF EMERGENCY CONTACT:	RED means EMERGENCY. Get help from a doctor.
1. Green—Go	Use Preventative Medicine (daily medication)
 Symptoms are minimal/none. Can continue normal activities of daily living. 	Medicine (Name/Dosage/Frequency/Route)
	Other Instructions:
2. Yellow—Caution	Take Quick-Relief Medicine to keep an symptoms under
	control. (PRN medications)
List symptoms for this section	Medicine (Name/Dosage/Frequency/Route):
1.	
2.	Other Instructions:
3.	
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:	