Pasco County Schools
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Dear Parent/Guardian:

According to District School Board of Pasco County Policy 5335, students who receive medication, health procedures or have special dietary needs (e.g. Diabetes Management, Diastat, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement) at school shall provide **annual** parental and healthcare provider authorization for the administration of medications and procedures.

If your child plans to carry his/her own supplies and/or perform any of the above medical procedures independently and without supervision during the next school year:

- Please return the *Authorization to Carry and Self Administer Diabetes Medication/Procedure, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement* form (available on the district website) signed by physician, parent and student **on or before the first day of school.**
- Please make sure your child carries all necessary supplies (Diabetes equipment or medication, Inhaler, Epipen, and/or Pancreatic enzyme supplement) at all times.

If your child may/will require assistance with administration of medication and/or procedures at any time during the next school year:

- Depending on your child's condition, please return either the *Severe Allergy (Anaphylaxis)* ***or*** *Seizure* ***or*** *Diabetes Medical Management Plan* form (found below) completed and signed by physician and parent **on or before the first day of school.**
- Please return the *Authorization for Medication Administration* form (available on the district website) for any medication that will need to be administered for your child **on or before the first day of school.** This form should be completed and signed by parent.
- Please provide the school clinic with all necessary supplies. Remember that medication must be brought to school by the parent / guardian (e.g. Insulin, Glucagon, Diastat, Inhaler, Epipen, etc.).

If your child may/will require assistance with special dietary needs during the next school year:

- Please submit completed *Diet Order Request* and/or *Severe Allergy (Anaphylaxis) Medical Management Plan* forms. The *Diet Order Request Form* will be reviewed/evaluated by the Food & Nutrition Services District Office on a case-by-case basis. Since school sites are not allergen free facilities, it may be beneficial to send a meal from home for the first few weeks of school.

While not all students' requests will be accommodated, our online menus identify common allergens and carbohydrate/nutrient information to assist you and your child in navigating their meal options. You can access this helpful tool online at https://schools.mealviewer.com/results/pasco%20county or download the mobile app on your smartphone or tablet.

Please feel free to call your child's School Nurse if you have any questions or would like to discuss your child's health status.

Thank you.

Pasco County School Health Services Program

4/2022

Pasco County Schools
Asthma Medical Management Plan

Student's Name:	Student ID:	DOB	School Year
School:		Grade:	Home Room:
Parent/Guardian #1:	Home #:	Cell #:	Work #:
Parent/Guardian #2:	Home #:	Cell #:	Work #:
Parent/Guardian E-Mail Address:			
Healthcare Provider(s):		Phone #:	Fax #:

Green Zone: Go!	Take these CONTROL (PREVENTION) Medicines EVERY DAY
You have **ALL** of these: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night **Peak flow:** _____ to _____ (More than 80% of Personal Best) **Personal best peak flow** _____	**Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.** ☐ No control medicines required. ☐ Dulera ☐ Symbicort ☐ Advair ____ Puff(s) ____ Times a day Combination medications inhaled corticosteroid with long-acting β-2-agonist ☐ Alvesco ☐ Asmanex ☐ Azmacort ☐ Flovent ☐ Pulmicort ☐ QVAR Inhaled Corticosteroid or inhaled corticosteroid/long-acting β-2-agonist ____ Puff(s) MDI ____ times a day Or ____ nebulizer treatments(s) ____ times a day ☐ Singulair or, _____ Take ____ By mouth once daily at bedtime Leukotriene antagnoist **For asthma with exercise, ADD:** ☐ Albuterol or _____, _____ Puffs with spacer 15 minutes before exercise
Yellow Zone: Caution!	Continue CONTROL Medicines and ADD RESCUE Medicines
You have **ANY** of these: • First sign of a cold • Cough or mild wheeze • Tight chest • Shortness of breath • Can do some, but not all of usual activities. **Peak flow in this area:** _____ to _____ (50% - 80% of Personal Best)	_____, _____ Puff(s) MDI **with spacer** every ____ hours as needed Fast-acting inhaled β-agonist **OR** _____, _____ nebulizer treatment(s) every ____ hours as needed Fast – acting inhaled β-agonist IF SYMPTOMS PERSIST MOVE TO RED ZONE – EMERGENCY!
Red Zone: EMERGENCY	Continue CONTROL & RESCUE Medicines and **GET HELP!**
You have **ANY** of these: • Can't talk, eat or walk well • Medicine is not helping • Breathing hard and fast • Blue lips and fingernails • Tired or lethargic • Ribs show **Peak flow in this area:** Less than: (less than 50% of Personal Best)	_____, _____ Puff(s) MDI with spacer every ____ Minutes, for ____ treatments Fast-acting inhaled à-agonist OR _____, _____ Nebulizer treatment every ____ Minutes, for ____ treatments Fast-acting inhaled à-agonist **CALL 911 FOR AN AMBULANCE!**

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including but not limited to, those that are oral, written, faxed, or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: _____ **Date:** _____

Physician's/Mid-Level Practitioner's Signature: _____ **Date:** _____

School Health Registered Nurse Signature: _____ **Date:** _____

Revised 5/2022

Pasco County Schools
General Guidelines for Administration of Medication at School

1. Administration of medication during school hours should occur only when medication schedules cannot be adjusted to provide for administration at home.
2. Medication will be administered by personnel trained by the registered professional school nurse.
3. Medication must be brought to school by the parent/guardian in the original prescription container with the original prescription label containing the following information:
    a. Student's name.
    b. Name of medication (Only FDA approved [regulated] medications will be administered at school, i.e., no herbal medications, supplements, essential oils, etc.).
    c. Dosage prescribed (If the dosage changes a new prescription bottle or script must be provided).
    d. Time of day to be taken (e.g., 9:45 AM) or if the medication is ordered as needed, how many hours in between doses (e.g., every 2 hours).
    e. Physician's name.
    f. Special instructions.
    g. Date of prescription (current, within one year).
4. No more than a month's supply (30-day supply) of medications should be brought to school by a parent/guardian, at one time.
5. All medications, whether self-carry or maintained in the clinic must be entered into the Health – Clinic System Medication Order Form. Medications administered in the clinic will be recorded on the Medication Administration Record (MAR) / Medication Inventory Record (MIR) and in the Health – Clinic System. Any changes to the time or dosage requires a new MAR / MIR to be created and a discontinuation of the Medication Order Form and a new Medication Order Form will need to be created with the updated information.
6. Medication received must be counted by at least two trained staff (additional signature from parent preferred). The amount and date received is to be recorded in the Health – Clinic System and on the individual *Medication Inventory Record* form.
7. A *Parent/Guardian Permission* form must be completed by the parent/guardian, granting the school permission to assist in the administration of such medication and which shall explain the necessity for such medication to be provided during the school day, including any occasion when the student is away from school property on official school business. Parents may not need to complete this form if authorization is provided (signed by parent/guardian) via student's *Medical Management Plan*.

*Note: It is preferred that the parent/guardian of a student obtain the needed dose(s) of medication for field trips in a separate, appropriately labeled prescription container. If that is not possible, the entire bottle of medication must be sent with a trained person to be administered on the field trip. Under no circumstances may medication be transferred from one container to another by anyone other than a registered pharmacist (no medications are to be placed in envelopes or baggies).

8. FDA approved (regulated), over-the-counter medication will not be administered at school, unless accompanied by a physician's statement, dated within the current school year (exception: *Healthy Student Program*). Over-the-counter medications must be brought to school by a parent/guardian in the original, unopened container.
9. Students will be allowed to carry metered dose asthma inhalers, pancreatic enzyme supplements, epinephrine auto-injectors and/or diabetes supplies, medication, and equipment with a completed *Authorization to Carry and Self Administer* form from their parent/guardian and physician (F.S.1002.20 (3)(h), (i), (k) and/or (j)).
10. If a student is participating in an after-school activity and has emergency medication in the clinic, the registered professional school nurse and clinic assistant must be notified by the parent/student.
11. No prescription narcotic analgesics will be administered at school.
12. Parental and healthcare provider authorization for the administration of medications and treatments is required each school year.
13. All medications must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent/guardian or designee, unused and unclaimed medication will be destroyed following proper disposal procedures. Legal Authority: section 1006.062, F.S.A.

Legal Authority: section 1006.062, F.S.A.

AUTHORIZATION TO CARRY AND SELF ADMINISTER ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

_____ _____

Student Name (print) Parent / Guardian Name (print)

_____ _____ _____

Student Number Grade Name of School

Name of Medication _____

In order for your child to carry and administer his/her own inhaler/epi-pen/or pancreatic enzyme supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the Medical Management Plan, which further sets forth the parental authorization and licensed prescriber's acknowledgement concerning the self-administration of medication.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me, in the student's Medical Management Plan, without assistance. This student should be allowed to carry and use the equipment/medication(s) listed above.

_____

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's inhaler/epi-pen/or PES. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use or misuse of such medication pursuant to s. 1002.20(3)(h),(i) and/or (k).

_____ _____

Date Parent / Guardian Signature

_____ _____

Date Student Signature

Revised 5/2015

Pasco County Schools

Annual Student Medication Administration Record (MAR)

Student Name: _____ Student #: _____ Grade: _____ DOB: _____ School: _____

Medication: _____ Dosage/time(s) to be given: _____ Exp. Date: _____

Allergies: _____ Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Codes: A = Absent N = Medication not sent by parents O = No Show

Teacher / Extension: _____

Initials and name of persons administering:

_____ _____

_____ _____

Note: This form must be saved for 7 years

Attach student photo if available

Updated: 02/2023

Medication Inventory Record

Transfer amount of medication from Previous month: __________

Student name: ______________________________ Student #: ______________ Grade: _____ DOB: ____________

Medication: ______________________________ Dosage: ____________________ Time: __________________

Date	Time	Start Count	Plus	New Amt Rec'd	Total	Minus	Amt Given	Minus	Wasted or returned / Field Trip	Actual Total W / H	Staff Initials	Staff Initials	Parent Initials	Action Taken Code	Comments	RN
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Codes: R = RN Notified, A = Admin Notified, P = Parent Notified, D = Dropped Med, E= Expired Med, F = Field Trip, O = Other

Initials and Signature of persons counting medications

Revised 6/2022