ASTHMA GUIDELINES

Asthma is the most common chronic condition of childhood. Comprehensive, individualized asthma education focuses on improving medical management which means recognizing and responding to attacks and medication.

A Doctor's signature is no longer required for a student to carry and self-administer an asthma inhaler in school. Only parent permission and prescription label are necessary.

Section 5. (105 ILCS 5/22-30) The School Code is amended by changing Section 22-30 as follows:
Section 22-30. **Self-administration of medication.**

- In this section: "Asthma inhaler" means a quick reliever asthma inhaler.
- **"Epinephrine auto-injector"** means a medicine, prescribed by 1) a physician licensed to practice medicine in all its branches, 2) a physician assistant who has been delegated the authority to prescribe asthma medications by his or her supervising physician, or 3) an advanced practice registered nurse who has a written collaborative agreement with a collaborating physician that delegates the authority to prescribe asthma medications, for a pupil that pertains to the pupil's asthma and that has an individual prescription label.
- **"Self-administration"** means a pupil's discretionary use of and ability to carry his or her prescribed asthma medication.

A school, whether public or nonpublic, must permit the self-administration of medication by a pupil with asthma or the use of an epinephrine auto-injector by a pupil, provided that:

- **the parents or guardians of the pupil provide to the school written authorization from the parents or guardians for the self-administration of medication or**
- **for use of an epinephrine auto-injector, written authorization from the pupil's physician, physician assistant, or advanced practice registered nurse; and**
- **the parents or guardians of the pupil provide to the school:**
  the prescription label, which must contain the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is administered, or

- **for use of an epinephrine auto-injector, a written statement from the pupil's physician, physician assistant, or advanced practice registered nurse containing the following information:**
  1. **the name and purpose of the epinephrine auto-injector**
  2. **the prescribed dosage; and**
  3. **the time or times at which or the special circumstances under which the epinephrine auto-injector is to be administered.**

The information provided shall be kept on file in the office of the school nurse or, in the absence of a school nurse, the school's administrator.

Reference: http://www.ilga.gov/legislation/publicacts/97/PDF/097-0361.pdf
Sample Plans: http://www.nhlbi.nih.gov/files/docs/resources/lung/asth_sch.pdf

The School is required to inform the parents or guardians, in writing, that the School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or the use of an epinephrine auto-injector by the student. **PLEASE READ PAGE 2.**

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

I/WE _____, parent(s) and/or guardian(s) of _____,
(*Please PRINT)* ***(Please PRINT)***

a student at _____School, hereby request and authorize the School to
{Please PRINT)

permit my/our child to self-administer asthma medication as prescribed by our child's physician, physician assistant, or advanced practice registered nurse.

_____**Parent/Guardian written permission and prescription label must be received by the school. Date: _____**

I/WE further acknowledge that this nonpublic school is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the student regardless of whether authorization was given by the student's parents or guardians or by the student's physician, physician's assistant, or advanced practice registered nurse. As parent(s) or guardian(s), I/WE indemnify and hold harmless this nonpublic school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an epinephrine auto-injector by the student regardless of whether authorization was given by the student's parents or guardians or by the student's physician, physician's assistant, or advanced practice registered nurse.

I/WE understand that any abuse of this right by the student or endangerment of another student or students by means of the student's possession of this medication may result in appropriate disciplinary action.

The permission for self-administration of medication or use of an epinephrine auto-injector is effective for the school year for which it is printed and shall be renewed each subsequent school year upon fulfillment of the requirements of section ILCS 5/22-30 of the Illinois School Code.

Provided the above requirements are met, a student with asthma may possess and use his or her medication or a student may possess and use his or her auto-injector while in school, at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, in before or after care on school-operated property.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

The completed form is to be filed in the student's Health file in the school.
Copies of both pages should be given to the parent/guardian.

To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

_____ **SCHOOL**, _____, **ILLINOIS**

_____	_____	_____	_____
Student Name (Last, First, Middle)	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the medication in the original labeled container as dispensed (**prescription** prescription medication) or the manufacturer's labeled container (n-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Side 2}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed the approval form on Side 2.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration of such medication. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and its employees or agents, jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

_____	_____
Parent/Guardian (PRINT)	**Parent/Guardian (PRINT)**
_____	_____
Parent/Guardian (SIGNATURE)	**Parent/Guardian (SIGNATURE)**
_____	_____
Address	**Address**
_____	_____
City, State, Zip Code	**City, State, Zip Code**
_____	_____
Home Phone Business Phone	**Home Phone Business Phone**
Cell Phone _____	**Cell Phone** _____

SIDE 1

Physician's Order

Student _____ Grade _____

_____ _____ _____
Medication/ Health Care Treatment Dosage Time(s) to be administered

_____ _____
Intended effect of this medication Expected side effects, if any

_____
List any other medications the student is taking

1) May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY**:
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

3) I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication needed.

(Please circle) YES NO

Administration Instructions:

_____ _____
Physician's /Prescriber's Signature Date Signed

_____ _____
Physician's/ Prescriber's Name (PRINT) (PRINT) Emergency telephone number

_____
Address City, State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____20___,
(Please circle one of the above)

by _____ on behalf of _____,Illinois
Signature of Principal Name School City