Natrona County School District #1 Asthma Management Plan

Student Name: _____ DOB: _____

Parent Name: _____ Parent Phone: _____

Provider's Name: _____ Provider Phone:_____ Fax: _____

Quick-Relief Medication	How Much to Take	How Often	Additional Instructions
	☐ 1 Puff ☐ 2 Puffs ☐ 1 Nebulizer Tx	☐ 4 Hours ☐ 6 Hours	*Take **only** as needed (see below-starting in yellow zone or before exercise) *If you need this medication more than two days a week, call physician to consider increasing controller medication & discuss treatment plan
	☐ 1 Puff ☐ 2 Puffs ☐ 1 Nebulizer Tx	☐ 4 Hours ☐ 6 Hours	

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. This authorization is only for the _____ school year.

Healthcare Provider Signature: _____

SCHOOL AUTHORIZATION FORM To be completed by Parent/Guardian and turned in to the school

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: I request that the school assist my child with the asthma medications listed on this form, and the Asthma Action Plan, in accordance with state laws and regulations.

❑ Yes ❑ No

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications.

❑ Yes ❑ No

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Student Name: _____ Date of Birth: _____

I, the undersigned, do hereby authorize (Healthcare Provider) _____

to provide health information from the above-named child's medical record to and from:

_____ (School or school district to which disclosure is made)

_____ (Contact person at school or school district)

_____(Address / City and State / Zip Code)

_____(Phone Number) _____ (Fax Number)

The disclosure of health information is required for the following purpose:
_____

Requested information shall be limited to the following: ❑ All health information; or ❑ Disease-specific information as described:
_____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from parent/guardian or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school/school district listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

Parent/Guardian Signature: _____ Printed Name: _____ Date: _____

Student Printed Name: _____