Medical forms/records School Nurse Fax:812-274-8791.

RE: Asthma Action Plan

Date: School Year 2026-27

Student: _____ DOB: _____.

Dear Parent or Guardian,

You have indicated your child has asthma on their Skyward medical form. In order for accommodations to be made at school, we must have a plan of care from the physician.

1. Please fill out the attached form, have the physician review, complete, sign, and return to us along with their inhaler.
2. If you do not have an appointment scheduled for the near future, your child's physician can fax this form or his/her own action plan to Madison Consolidated Schools at 812-274-8791
3. We do require this to be completed annually.
4. If you have any questions or concerns please feel free to contact your child's school nurse.

Thank you for your cooperation and for assisting in keeping your child safe at school.

Madison Consolidated Schools

Renee James, RN

District Nursing Team Coordinator

RJ 2026

MADISON CONSOLIDATED SCHOOLS STUDENT INDIVIDUALIZED HEALTH CARE PLAN

Includes applicable physician orders and EAPs
(emergency action plans)

SCHOOL YEAR: 2026-2027

STUDENT INFORMATION: 504 Plan Yes.___ No____ **ALLERGIES:** _____			
Student:	D.O.B.	**Grade:**	**School:**
Counselor:	**BUS:**		**Driver:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**

Medical Diagnosis:

Daily Medications	Notable side effects	Time of Admin

Symptom(s) of Concern:	Intervention:

Goals:	Evaluation:

DIET:	ACTIVITY:	ENVIRONMENTAL MODIFICATIONS:

SCHEDULE OF DAILY CARE:

Breakfast	
Lunchtime:	
Afternoon:	

FIELD TRIP/EXTRA-CURRICULAR ACTIVITY CONSIDERATIONS:

CONTINGENCY PLANNING: (Who will provide care in event of the nurse absence)

Trained VHA:	Sub Nurse	Health Room Assistant
Yes or No	Yes or No	Yes or No

SUPPLIES NEEDED: Parents will provide all needed supplies for treatments and orders i.e wipes, diabetic supplies, snacks or food, emergency meds,cath supplies, gtube supplies, etc.

"I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my licensed healthcare provider if necessary, and for this healthcare information to be shared with pertinent school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices."

RN Signature:_____Date: _____

Parent Signature: _____ Date: _____

ASTHMA Emergency Health Care Plan

Physician's Authorization to Administer Medication at School
Medical forms/records for School Nurse: Fax # 812-274-8791

School Year:_____School:_____ Grade: _____

Student: _____Date of Birth: _____

- This student has asthma for which the following medications have been prescribed for treating and preventing emergencies.
- This student has been trained in the use of these medications.
- The staff of Madison Consolidated Schools has permission to give/assist with these medications as needed.

Medication	Dose	Route	Time

Please notify parents if these do not relieve the student's problems

Name of parent: _____ Phone Number:_____
Alternate person to reach if parent is unavailable:_____ Phone Number:_____

_____ This student possesses enough skill and maturity to carry the medication/inhaler and use it under the general supervision of school personnel.

_____ This student's medication must be kept by school personnel and administered only with detailed and specific supervision.

_____ This student's condition does not warrant having an inhaler at school except during exacerbation of condition and will be prescribed at that time.

Adverse effect that should be looked for: _____
Potential for abuse or addiction: _____
Comments:
_____
_____

Physician's Name: (Please Print) _____ Date: _____
Physician's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____

2026 RJ



AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION 2026/2027

Student Name: _____ DOB: _____
Parent or Legal Guardian:_____Phone: _____
Address: _____ City/State/Zip: _____
School: _____Grade: ___ Teacher: _____

Medical Condition(s): _____
_____

Authorization for the exchange of information is hereby granted between Madison Consolidated Schools and the following agency(s) and/or individual(s):

1._____ _____
Name of physician, agency, individual, etc. Phone Fax

2._____ _____
Name of physician, agency, individual, etc. Phone Fax

3._____ _____
Name of physician, agency, individual, etc. Phone Fax

Effective: 2026-2027 School year
Purpose: The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital/ Medical office setting and the school setting.

Treatment Orders:____ Emergency Action Plans _____Health/Medical Record Information: _____

• This authorization is valid for twelve (12) months from the date of signing. At any time, I may revoke this release in writing. If I want it to expire on a different date, then that date is:___ . Revocation does not affect release of medical records made prior to the revocation. I understand that I have a right to receive a copy of this form after signing.
• I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

• Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
• I understand for the purpose of providing the most appropriate instruction and assistance in school, I am giving my permission for mutual exchange of educational evaluations or medical evaluations.
• Parents of a student with a disability have protection under the procedural safeguards described in the law: 511 IAC-7-37-1. If I have not previously received a copy of written notice of procedural safeguards and a list of resources for help in understanding my rights, I understand these can be obtained from my child's teacher or the Special Education office.
• By my signature below, I indicate that I am the parent or legal guardian of the above named child. I authorize the release and use of the information in accordance with the rights,restrictions and understandings above to ensure health, safety and continuity of care for my child.

Parent or Legal Guardian's Signature: Date:

_____ _____