Picture

Stillwater Area School District #834

ASTHMA

Questionnaire and Medication Orders

We have report that your child has a breathing problem or some form of asthma.
Please help us to understand the details of his/her condition, now referred to as "episodes."
If this has been a problem in the past, but is no longer a current concern, please sign below so that your child's health record can be updated.
Parent/Guardian name: _____

Student's name_____ Date of Birth_____ Grade/Teacher_____

Parent/Guardian_____ Homephone_____

Phone (Mom) _____ (Dad)_____ **Physician name**_____

Hospital preference (if 911 transport needed) _____ In the event of an emergency, contact with a parent/guardian will be attempted first; before transfer occurs.

1. At what age did your child have his/her first episode? _____
b. How severe was the first episode? (circle) **MILD MODERATE SEVERE** Emergency Department or hospital care? **YES NO**
c. When was the last time your child experienced an episode? (date):_____
d. How severe was this last episode? (circle) **MILD MODERATE SEVERE**
e. If applicable, how many episodes required either hospital or Emergency Department care during the past year? _____
f. How many days did your child miss school last year due to his/her asthma: _____ days
g. During the past year, has your child's asthma ever prevented him/her from taking part in sports, recess, physical education or other such activities? **YES NO** Don't Know

2. Does your child have any other known allergy or other triggers? **YES NO** If so, please circle:

Smoke	Animals/pets	Dust/dust-mites	Cockroaches
Grass/flowers	Mold	Chalk/chalk dust	Strong smells/perfume
Stress or emotional upset		Changes in weather/very cold or hot air	
Having a cold/respiratory illness		Exercise, sports, or playing hard	
Foods (which ones): _____		Any other triggers: _____	

3. Has your child had allergy testing by a medical clinic? (circle) **SKIN BLOOD None**
b. Does your child know what triggers to avoid? **YES NO**
c. Have any allergy shots been started? **YES NO** Please list types:_____
d. Does anyone in the household smoke? _____ If yes, where: _____

4. What are the pre-warning signs (physical & emotional changes) that indicate that your child may be having an asthma episode?

_____

a. What are the signs that indicate that your child is having an actual episode? (ie. Wheezing, cough without relief, respiratory difficulty) Explain: _____

_____

b. Does your child recognize when he/she is having an episode? (circle) **YES NO**

Medications taken at Home

Medication name	How much and how often?	When is it taken?

Student name:_____ Date of Birth: _____

For Health Care Provider: Please complete this section:

Medications to be taken at School

Medication name and route	How much (dose) and how often?	When is it taken?

5. **School management of asthmatic episode**: be specific: (ie: bronchodilator before physical activity or cold weather recess; scheduled times vs. prn; Additional medications during illness.) **A detailed Asthma Action Plan (AAP) for this student will provide the school with the needed information. Please attach a copy of this student's AAP to this questionnaire in order for the school to administer medication.**

_____

a. Does the student know when medication is needed? YES NO b. Spacer required for their inhaler? YES NO
c. Is student inhaler proficient? YES NO Neb form needed? YES NO Does student need assistance? YES NO
d. Student may possess and self-administer their inhaler (grade 6-12+) YES NO
Any other comment:_____

Physician/NP/PA signature _____ Date _____

Clinic Name _____ Clinic Phone Number _____

6. At what point do you want the school to contact you, as parents, regarding your child's breathing episode? _____

7. If your child continues in distress, what action do you advise the health office to take?

_____

8. If there anything else you would like to add about your child's breathing?

_____

Parent Guardian Authorization

I request that the above medication(s) be given during school hours or while on field trips for the above mentioned condition as ordered by my child's physician/licensed provider. I will notify the school of any change in the medication (dosage changes, or stopping of medication, etc.) I give permission for the school nurse to consult with the above student's physician/licensed prescriber regarding any questions that arise with regard to the listed medical condition and medication if used. Medications must be in their original containers, clearly labeled with the child's name and directions for giving the medication.

☐ I request my child (grade 6-12+) to be able to carry and take their own asthma medication and/or inhalers at school as prescribed above. I release the school personnel from liability in the event adverse reactions result from taking the medication(s) by the student outside of the health room.

☐ My child will sign and follow the self-administration of asthma medication student agreement.

Parent/Guardian Signature _____ Date _____

Self-Administration of Asthma Medication

Student Agreement

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration technique.
3. Not allow anyone else to use my medication.
4. Keep a supply of my medication with me in school and on field trips.
5. Notify the school health office personnel if any of the following occurs:
   - My symptoms continue or get worse after taking the medication.
   - My symptoms reoccur within 2-3 hours after taking the medication
   - I suspect that I am experiencing side effects from my medication
   - Other _____
6. I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

_____ _____

Signature of Student **Date**

Name of Student_____ Birth Date:_____

School: _____ Grade: _____