Asthma Packet

** New forms are required at the beginning of each school year

PLEASE NOTE:

The Asthma Questionnaire form is for the parent to complete to help us better understand your child's asthma

- The Asthma Action Plan is only for your child's doctor to complete
- For Inhalers at school (only), you may provide a copy of the prescription instead of having the doctor complete the AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
- If your child is going to self-carry their inhaler, you both must complete and sign the self-carry portion on the second page of the AUTHORIZATION FOR ADMINISTRATION OF MEDICATION form.

Thank you for your help!

Asthma History Questionnaire

You indicated during registration that your child has a history of asthma. Please provide us with additional information about your child's health needs by responding to the following questions.

Student's Name_____ **DOB**_____

School_____ **Grade**_____

Primary Healthcare Provider:_____ Phone:_____

- ❑ **Age of diagnosis:**_____
- ❑ **How many times has your child been in the ER for asthma in the past year:**_____
- ❑ **How would you rate the severity of your child's asthma:**

  (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)
- ❑ **When was your child's last asthma attack?:** _____
- ❑ **How many school days would you estimate your child missed last year because of asthma?:** _____
- ❑ **My child's known asthma triggers include:** _____
- ❑ **My child's symptoms include: (circle)**

  Coughing Wheezing Prolonged expiration

  Tightness in Chest Gasping for air Skin/lip color changes (pale/ blue)
- ❑ **What does your child do at home to relieve asthma symptoms? (circle) Breathing exercises Rest/relax drink liquids take medication**

  other (describe)_____
- ❑ **Can your child identify his/her early warning signs and symptoms that indicate onset of an asthma episode and need for quick-relief medicine?**

  □ yes ◁ no
- ❑ **Can your child identify his/ her asthma symptoms that indicate the need for help or medical attention?**

  L Yes ▷ No
- ❑ **List Current Medications: (name, dosage, frequency)**

  _____

  _____

  _____
- ❑ **Does your child use a spacer? □ Yes □ No**
- ❑ **Does your child use a peak flow meter? □ Yes □ No Personal Best:**_____

Additional comments: _____

_____

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

Reviewed by RN:_____ **Date:**_____

Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION.

Name _____ DOB ____/____/_____

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (____) ____-_____ Signature _____

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

Please send a signed copy back to the provider listed above.

GLENVIEW SCHOOL DISTRICT 34
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

ENGLISH **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

Parent or Guardian:
Both pages of this form must be completed prior to the administration of any medication in accordance with district policy and guidance from the Illinois State Board of Education.
All medications provided to the school must be:

- In their **original prescription container,** labeled with the name of the student, prescribing physician, name of medication, dosage, route, time to be given and name of pharmacy **OR**
- In the **original manufacturer's package**, if non-prescription medication.
- The parent/guardian or other responsible **adult should bring any medication to the school health office**.
- Medication **cannot** be expired.

Student's Name:_____ **Date of Birth:** _____

To Be Completed by the Physician:

Only medication which is prescribed by a physician and which are absolutely necessary for the critical health and well being of the student shall be given. Please indicate whether this medication must be taken during the school day. **Yes** ☐ **No** ☐

Medication: _____ **Dosage:** _____

Route:_____ **Frequency:**_____ **Scheduled** ☐ **PRN** ☐

Additional Specific Instructions: _____

Diagnosis/ Indication / Intended Effect:_____

Possible Side Effects: _____

Other Medication(s) Student is taking: _____

Duration of Order: Current School Year or other: (specify duration) _____

Emergency Medications: Epinephrine or Inhaler: (MD/PA/NP must initial below):

_____**Student may self-carry/ self-administer their emergency medication.**
I have instructed the student on the administration of this medication and find that they are able to administer this medication independently. (It is recommended that "back-up" medication be stored in the school health office).

Licensed Prescriber:

Prescriber name: _____ **Phone Number:** _____
(printed)

Signature: _____ **Date of Order:** _____

GLENVIEW SCHOOL DISTRICT 34
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

Parent/ Guardian Authorization for School Medication

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Glenview School District 34 and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, albuterol or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction, asthma attack or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff 1-1-19. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a certificated and registered school nurse, and I specifically consent to such practices, and.

I agree to indemnify and hold harmless District 34, members and its employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.
In the event an epinephrine auto-injector is administered to my child, I acknowledge and understand that the school district personnel will call 9-1-1 to alert emergency services.

I agree to notify the school of any changes in medication for my child's condition.

I understand that I will need to pick up any unused doses of the medication at the end of the school year. Unused medications will not be sent home with my child and will be destroyed if not picked up by the last day of school.

Parent/ Guardian Signature: _____ Date: _____

Guardian Phone Number(s): _____

Parent/ Guardian Agreement Authorizing Self Carry/ Self Administration of Asthma Medication or Epinephrine Auto Injector
Before your child will be allowed to self-carry/ self-administer medication, we must ask you to sign below:

I agree with the provider statement above, and therefore authorize Glenview District 34 and its employees and agents, to allow my child to self-carry and/or self-administer the above named medication (1) at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) during before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/ guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff. 1-1-19)

The permission for self-administration of medication is effective for the school year in which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. We recommend that you provide an additional dose of the medication to be kept at the school in the event that your child forgets or loses his/her medication.

Your signature below indicates receipt of the above information as well as authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian Signature: _____ Date_____

Witness:_____ Date_____

The student must complete the following section (for self-carry):
I agree to:

1. Demonstrate correct use of the inhaler or epinephrine auto-injector using a trainer to the school health office staff
2. Never share my medication with another person
3. Notify a responsible adult if there is no improvement in my breathing after using my inhaler **OR**
4. Immediately notify a responsible adult if I use my epinephrine auto-injector.

Student Signature_____ Date _____