VICTOR VALLEY UNION HIGH SCHOOL DISTRICT
Health Services
16350 Mojave Drive, Victorville, CA 92395-3655
Phone: (760) 955-3201 ext. 10427 Fax: (760)483-7966
Julie Dieppa, RN, BSN District Nurse

VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

STUDENT ASTHMA INFORMATION SHEET

Student name:_____ ID:_____

Describe type of symptoms student experiences (i.e., wheezing, coughing, etc.…)

_____

_____

Date of last asthma attack_____

About how often does student have an attack? daily___weekly___ monthly___ yearly___

What usually causes or triggers attack? (exercise, stress, weather, illness, etc.)

_____

_____

Medications student takes: Name, dose, frequency:

_____

_____

Side effects of medication that your student experiences:

_____

_____

Does your student use a peak flow meter? _____

If so, what is the student's current best peak flow? _____

Does your student use a spacer for their inhaler? _____

Additional information/instructions:

_____

_____

Parent/Guardian Signature: _____ Date:_____

School Phone # _____
School Fax # _____

Symptom Based – Asthma Action Plan

Student Name: _____ **Date of Birth:** _____ **School:** _____

Parent/Guardian: _____ **Home Phone:** _____ **Cellular:** _____

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home): **Please CHECK box if needed for use at school.**

A. "QUICK-RELIEF" Medication Name	1.	☐ For School *
	2.	☐ For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	1.	☐ For School *
	2.	☐ For School *
	3.	☐ For School *
C. BEFORE PE, Exertion: Med Name	1.	☐ For School *
	2.	☐ For School *

2. For student on inhaled medication (all students must go to Health Office for oral medications)
- ☐ Assist student with inhaled medication in Health Office*
- ☐ May self-administer/self-carry inhaler medication.* Student demonstrates competence. (**Not** recommended in elementary school)

3. A spacer device (e.g. Aerochamber) use is advised for all students at school.

4. Check known triggers: ☐tobacco ☐pesticides ☐animals ☐birds ☐cockroaches ☐cleansers ☐car exhaust ☐perfume ☐candles ☐mold ☐dust ☐cold air ☐exercise ☐smog ☐pollens ☐other _____

5. Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:

Green Zone

Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities

YELLOW ZONE	Action for school:
Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions	1. Give "Quick – Relief" Medication(s)* 2. Notify Parent if symptoms are NOT relieved by medication after 15 - 20 min 3. If symptoms are NOT RELIEVED follow **School Emergency Plan** below 4. If symptoms are relieved, student may return to class **Notify Parent if "Quick – Relief" inhaler has been used more than two times this week (if not related to physical activity)*

RED ZONE	Action for school:
Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restrictions, symptoms are the same or worse after 30 minutes in Yellow Zone	**1. Give "Quick – Relief" Medication(s)** **2. If symptoms are not improved within 15 to 20 minutes by student's "Quick – Relief" medication, or symptoms become worse, follow School Emergency Plan below**

SCHOOL EMERGENCY PLAN

1. ***REPEAT*** "Quick-Relief" medication(s) now
2. ***Call 911*** – Seek emergency care
3. Contact parent/guardian and school nurse
4. REPEAT "Quick-Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved
5. Stay with student until paramedics arrive

Physician Name: _____ ***Physician Signature:*** _____ ***Date:*** _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ ***Date:*** _____ **Phone Number:** _____

* Medication Administration Form Required

School Phone # _____
School Fax # _____

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

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

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ ***Date:*** _____

Physician Name: _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Parent Request
For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school. ***Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.***

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

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ ***Date:*** _____

Parent Signature: _____ ***Date:*** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
(760) 552-6700 • (760) 242-5363 FAX

Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

School Site: _____ LEA of Residence: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ E-mail Address: _____

RECEIVING AGENCY

Individual/Agency RECEIVING Information: Victor Valley Union High School District

Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92395

Contact Name: Julie Dieppa, RN Phone: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvuhsd.org

☐ **I agree that the Individuals/Agencies above may mutually share information.**

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

_____ **REVOCATION:** I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

_____ **REDISCLOSURE:** I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the receipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

_____ **HEALTH INFORMATION:** I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

☐ Medical/Medication ☐ Mental Health/Psychiatric ☐ Drug/Alcohol
☐ Educational Records ☐ STD/HIV Test Results ☐ Other: _____

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

I request that the information released pursuant to this Authorization be used for the following purposes:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ Date: _____

Student Signature: *(if applicable)* _____ Date: _____