**TOWN OF TRUMBULL**
**SCHOOL HEALTH SERVICES**

| Grade |
|---|
| Teacher |

# Student Asthma History and Medication Authorization

| Family Information | | |
|---|---|---|
| | **Student's Name** | **Date of Birth** |
| | **Mother/Guardian** | **Father/Guardian** |
| | **☐Home ☐ Work ☐ Cell** | **☐Home ☐ Work ☐ Cell** |
| | **☐Home ☐ Work ☐ Cell** | **☐Home ☐ Work ☐ Cell** |

**Student's Asthma History**
To be completed by child's parent/guardian

**When was your child's asthma diagnosed?**

**What triggers your child's asthma attacks?** (Please check all that apply)

| | | | |
|---|---|---|---|
| ☐ Illness | ☐ Emotions | ☐ Medications | ☐ Respiratory Infections |
| ☐ Allergies | ☐ Exercise | ☐ Cigarette Smoke | ☐ Chemical Odors |
| ☐ Fatigue | ☐ Foods | ☐ Weather | ☐ Other: |

**Allergies:**

**What symptoms does your child exhibit when having an asthma attack?**
☐ No symptoms ☐ Cough ☐ Wheeze ☐ Chest Tightness ☐ Facial Changes ☐ Other:

**Please list the medications your child takes for asthma at home on a regular or as needed basis:**

| Medication | | Medication | | Medication | |
|---|---|---|---|---|---|
| Dose | Frequency | Dose | Frequency | Dose | Frequency |

**Medication to be Administered in School**
**To be completed by child's provider**

This child's **Asthma Severity** is: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

| Medication | | Medication shall be administered from: | Provider's Stamp |
|---|---|---|---|
| Dosage | Route | Start Date | |
| Time to be administered | | Stop Date | |
| If PRN, frequency: | | Provider's Phone # | |
| Administer with Spacer ☐ Yes ☐ No | | Provider's Fax # | |
| Relevant Side Effects | | | |
| **Provider's Signature** | | **Please print name** | **Date** |

**Approval for Self-Administration of Medication**

This authorization grants permission for capable students, with a chronic medical condition, to carry and self-administer emergency and some non-controlled medications with the consent of the student's prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-4, and Board of Education policy.

| | | | |
|---|---|---|---|
| Prescriber Authorization for Self-Administration | ☐ Yes ☐ No | Signature | Date |
| Parent/Guardian Authorization for Self-Administration | ☐ Yes ☐ No | Signature | Date |
| School Nurse Authorization for Self-Administration | ☐ NR ☐ Yes ☐ No | Signature | Date |

**Parent Authorization for Administration of Medication by School Personnel**

*Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written order from an authorized prescriber, (physician,* ***dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of*** *the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs, to a student.*
*Medications must be delivered to the nurse by a responsible adult in the original, properly labeled container dispensed by a physician/pharmacist.*
*Over-the-counter medications must be delivered in an unopened, properly labeled original container.*

| **Parent/Guardian Signature** | **Date** |
|---|---|
| | |