Asthma and Allergy Foundation of America

Student Asthma Action Card

National Asthma Education and Prevention Program

Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

ID Photo

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

Emergency Plan

Emergency action is necessary when the student has symptoms such as, _____, _____, _____, _____ or has a peak flow reading of _____.

- **Steps to take during an asthma episode:**
  1. Check peak flow.
  2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
  3. Contact parent/guardian if _____
  4. Re-check peak flow.
  5. Seek emergency medical care if the student has any of the following:
     - ✔ Coughs constantly
     - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
     - ✔ Peak flow of _____
     - ✔ Hard time breathing with:
       - Chest and neck pulled in with breathing
       - Stooped body posture
       - Struggling or gasping
     - ✔ Trouble walking or talking
     - ✔ Stops playing and can't start activity again
     - ✔ Lips or fingernails are grey or blue

If This Happens, Get Emergency Help Now!

- **Emergency Asthma Medications**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

See reverse for more instructions

Daily Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food _____
☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds
☐ Other _____

Comments _____

- **Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

- **Peak Flow Monitoring**

Personal Best Peak Flow number: _____

Monitoring Times: _____ _____ _____ _____

- **Daily Medication Plan**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Comments / Special Instructions

_____

_____

_____

For Inhaled Medications

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

School Medication Administration Authorization Form

This order is valid only for school year (current)_____, including summer session.

School:_____

This form must be completed fully in order for school to administer the required medication.
A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- ★ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ★ Non-prescription (over the counter) medication must be in the original container with the label intact. Students' names and date of birth must be on the medication.
- ★ Over the counter medications, except topical creams/ointments, require physician signature.
- ★ An adult must bring the medication to school. Any controlled substance must be counted with the parent and a staff member.
- ★ If a controlled substance is permitted for self carry, only the daily dose(s) needed are allowed to be carried.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade:_____

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____ Route:_____

Time/frequency of administration:_____ If PRN(as needed), frequency:_____

If PRN(as needed), for what symptoms: _____

Special administration instructions:_____

Relevant side effects: ▫ None Expected ▫ Specify:_____

Special storage requirements: ▫ None ▫ Refrigerate ▫ Other:_____

Medication Shall be administered from:(Month/day/year):_____ to _____

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

Prescriber's Signature:_____

Date:_____

Parent/Guardian Authorization

I/We request school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication. I/We authorize the school personnel to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date:_____

Home/Cell Phone #:_____ Work Phone #:_____

Self Carry/Self Administration of Medication Authorization/Approval

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and parent.

This student may carry this medication: ▫ Yes ▫ No

This student is both capable and responsible for self-administering this medication:

▫ Yes, supervised ▫ Yes, unsupervised ▫ No

Prescriber's authorization for self carry/self administration of medication: _____
Signature/Date

Parent's approval for self carry/self administration of medication:_____
Signature/Date

LHSA

A Community Action Agency

EARLY HEAD START/HEAD START
ASTHMA PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent/Guardian:

You have indicated on your child's enrollment forms, emergency card and/or health history that your child has asthma. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child as having asthma? Yes ____ No ____

2. Has your child had symptoms of asthma in the last 12 months? Yes ____ No ____
   Symptoms of asthma include the following:
   - ✓ Coughing that won't go away
   - ✓ Wheezing that makes it hard to breathe
   - ✓ Wheezing with a cold
   - ✓ Wheezing without a cold

3. Does your child currently take medication for asthma? Yes ____ No ____
   If yes, please list all medications _____

4. Please check which of the following trigger your child's asthma.

__ animal dander	__ molds	__ respiratory infections
__ cold air	__ perfumes	__ strong odors/fumes
__ dust	__ pollen	__ tobacco smoke
__ weather changes	__ exercise	__ cockroach allergen
__ foods (list) _____		__ other

5. Does asthma prevent your child from participating in school activities? Yes ____ No ____
   If yes, please explain. _____

6. Does your child need medication at school for treatment of asthma? Yes ___ No ___

****If your child needs medical attention or medication for asthma while at school, you and your child's physician must complete and sign an ASTHMA ACTION PLAN.**

7. Is there anything else we need to know about your child's medical condition? Yes ____ No____
   _____

Parent/Guardian Signature _____ Date: _____
Thank you for your cooperation.

_____ _____ _____
Early Head Start /Head Start Staff Phone # Date

OLHSA

A Community Action Agency

OLHSA EARLY HEAD START/HEAD START
Medication Parent Consent Form

All prescription medicine must be in the original pharmacy container, clearly labeled with the child's name, physician's name, date and instructions for administering medication. To protect your child and others, please **do not leave** any medication in your child's belongings, cubby, locker or classroom. Medication must be personally delivered to a Head Start/Early Head Start staff member.

I agree to hold OLHSA Head Start/Early Head Start and its staff free from any liability in the event of allergic reaction or mishap occurring as a result of medication being administered to my child at my request and according to the instructions provided by a physician, at the center or field trip.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____