DAWN FOX
Nurse Administrator

Dear Parents,

According to our records, your child has asthma, or has had asthma medicine at the school in the past. It would be helpful to have updated information about your child's asthma so we can plan for the care of your child at school. Enclosed is an **Asthma History** form requesting updated information about your child. Please complete it and return it to the health room before the start of the next school year.

If your child needs to take medication during school hours or at school sponsored events next year, please have your health care provider complete the **Health Care Provider Medication and Treatment Plan for Asthma** form. Bring the completed Health Care Provider Medication Request and Treatment Plan for Asthma with the Parent Permission signed with the medication in a properly labeled container when school begins in the fall.

Please contact Health Services or your School Nurse if you have any questions.

Sincerely,

Dawn Fox, MS, RN, NCSN

516 176th Street East • Spanaway, Washington 98387 • 253.800.2000 • bethelsd.org

	HEALTH CARE PROVIDER MEDICATION REQUEST AND TREATMENT PLAN FOR ASTHMA

SCHOOL YEAR	SCHOOL	FAX

Student Name: ______________________________ has asthma and may need to take medication at school.

The treatment plan for managing asthma at school is a follows: (check all that apply)

Diagnosis: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

□ Administer rescue medication if student experiences symptoms *(coughing, difficulty breathing, wheezing, chest tightness)*

DRUG & DOSAGE FORM	DOSE, TIME, AND MODE OF ADMINISTRATION
□ Albuterol Inhaler □ With Spacer	□ 2 (or) puffs by mouth 5 20 minutes prior to exercise, as needed *(may repeat with 2)* □ 2 (or _____) puffs by mouth every 3 4 hours as needed for symptoms. □ If no relief after treatment, call 911 and notify appropriate staff. □ Other:
□ Albuterol via Nebulizer □ Levalbuterol via Nebulizer □ mouthpiece □ mask	□ 1 unit dose every _____ hours as needed for symptoms □ May repeat and call 911 □ Other:
□ EpiPen □ EpiPen Junior	For severe asthma or allergic emergency

Use peak flow meter per attached directions.

Student is to inform school nurse if using albuterol inhaler more than 4 times/day or if asthma causes awakening at night.

Other:

- □ Student has been instructed in use of device needed to administer medication.
- □ Student has demonstrated the skill even necessary to use the medication appropriately.
- □ Student recognizes symptoms of asthma and will seek assistance if needed.
- □ Student may carry and self administer the medication ordered above.

Health Care Provider's Signature Phone *(for clarification on orders)* Fax

Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRRENT SCHOOL YEAR ONLY

Parent/Guardian's Permission:

I request that the school nurse, principal, or designated staff member be permitted administer to my child *(name of child)* ______________________ ___ or allow my child to carry and self administer as indicated above, the medication prescribed by *(name of provider)* ____________________________ for the ____________ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self administers, in accordance with the health care provider's directions. If notified by the school personnel that medication remains at the end of the school year, **I will collect the medication from the school or understand that it will be destroyed.** I am the parent or the legal guardian of the child named.

Parent/Guardian Signature: __ __ __ ___ __ __ Date: ______________________

Phone Contacts: *Home:* *Cell:* __ *Work:* _ *Other:* _

STUDENT DEMONSTRATES SKILL LEVEL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE.

School Nurse Signature: ____ ____ Date: ____________________________

THANK YOU FOR YOUR ASSISTANCE. PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE.

4/29/16 rfc

Bethel School District
ASTHMA HISTORY FORM

Student's Name: ____ Date of Birth: ___________________

Person completing this form: ____ Date: ___________________

Parent/Guardian Name: ____

Primary Phone: __________________________________ Work Phone: ______________________________

Alternate Contact: ____ Phone: ___________________________

Healthcare Provider Managing Asthma: ________________________________ Phone: _______________________

When was this student first diagnosed with asthma? ____

How many times has this student been seen in the emergency room for asthma in the past year? _______________

How many times has this student been hospitalized overnight for asthma in the past year? ____________________

Has this student ever been admitted to an intensive care unit for asthma? YES NO

If yes, when? ____

Please circle the number that best describes the severity of this student's asthma?

NOT SEVERE 1 2 3 4 5 6 7 8 9 10 SEVERE

How many school days would you estimate this student missed because of asthma last year? __________________

What triggers this student's asthma?

- ☐ Exercise
- ☐ Stress
- ☐ Pollen
- ☐ Wood Smoke
- ☐ Respiratory Infections
- ☐ Strong odors or perfumes
- ☐ Molds
- ☐ Indoor Dust
- ☐ Temperature changes
- ☐ Carpets
- ☐ Cigarette Smoke
- ☐ Outdoor Dust
- ☐ Animals: ____
- ☐ Other: __________________________________
- ☐ Foods: ____ ____

Please list known allergies: ____

____

What does this student do at home to relieve asthma symptoms (check all that apply)?

- ☐ Breathing Exercises
- ☐ Rest /Relaxation
- ☐ Takes Medication (see below)
- ☐ Drinks Room-Temperature Water
- ☐ Other (describe): ____

Is an Epinephrine Auto-Injector prescribed for this student? YES NO

Please list medications this student takes for asthma (daily and as needed):

MEDICATION NAME	AMOUNT	DELIVERY METHOD	DAILY	HOW OFTEN DAILY?	AS NEEDED

What herbal remedies, if any does this student take for asthma? ____

____

Does this student use any of the following aids for managing asthma?

- ☐ Valved Holding Chamber
- ☐ Spacer Device
- ☐ Valved Holding Chamber with Mask
- ☐ Peak Flow Meter (personal best if known) __________________
- ☐ Other: ____

Please check special needs related to this student's asthma (check all that apply):

- ☐ Avoidance of certain foods
- ☐ Physical Education Class
- ☐ Animals in the classroom
- ☐ Access to water
- ☐ Recess
- ☐ Field Trips
- ☐ Transportation to and from school
- ☐ Observation of side effects
- ☐ Other: ____

If you checked any of the above boxes, please describe needs:

____

____

____

Has this student had asthma education? YES NO

I am interested in additional asthma education for: MYSELF MY STUDENT

Parent/Guardian Signature: ____ Date: _____________________

Nurse Signature: ____ Date: _____________________

tll June 2021

AMES: Asthma Management in Educational Settings
American Lung Association of WA *February 2001*