PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
ASTHMA

Child's Name _____ Birthdate _____ Age _____ Grade _____
Teacher _____ Information provided by _____ Date _____
Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? _____ Phone _____
Who does your child see for asthma management? _____ Phone _____
When was your child diagnosed with asthma? _____ at age _____
Has your child been diagnosed with any other medical conditions?
☐ No ☐ Yes (explain) _____
What **symptoms** does your child experience during an asthma episode? _____
How would your child describe these symptoms? _____
How often does your child experience asthma symptoms? _____
Does your child use a quick relief inhaler (Albuterol/ Ventolin/ Proventil, etc.) more than 2 times per week? (This does not include using it before physical activity). ☐ No ☐ Yes (explain) _____
What **triggers** (allergens, irritants, exercise, respiratory infections, changes in temperature) cause asthma symptoms for your child? _____
Has your child gone to the emergency room or been hospitalized for treatment of asthma?
☐ No ☐ Yes (explain) _____

What medications does your child take to manage his/her asthma?

Name of Medication	**Amount**	**When taken**

Has your child been instructed on when and how to take these medications independently? ☐ No ☐ Yes
Is your child participating in sports or school sponsored extracurricular activities? ☐ No ☐ Yes
Does your child carry his/her inhaler in school and at these activities? ☐ No ☐ Yes
Has asthma caused your child to be restricted from physical education/recess activities?
☐ No ☐ Sometimes ☐ Often (explain) _____
Has asthma caused your child to miss school? ☐ No ☐ Yes Number of days missed last year _____
Has your physician completed an **Asthma Action Plan** for your child? ☐ No ☐ Yes
Have you and/or the physician reviewed the **Asthma Action Plan** with your child? ☐ No ☐ Yes
Does your child use a **peak flow meter**? ☐ No ☐ Yes
Is your child comfortable alerting others when experiencing asthma symptoms? ☐ No ☐ Yes
Does your child wear a "**medic alert**" necklace/bracelet? ☐ No ☐ Yes
Do you feel your child's understanding of his/her asthma is:
☐ very good ☐ good ☐ fair ☐ limited
Has your physician indicated **in writing** that your child needs any special accommodations to participate in school activities? ☐ No ☐ Yes (explain) _____

Comments: _____

Pittsford Central School District

Permission to Administer Medication in School and During School Sponsored After School and Weekend Activities/Sports

School Year _____
Grade _____
Teacher _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Student's Name _____ Date of Birth _____

Medication _____ Dose _____ Route _____ Time(s) _____

Purpose _____

Side Effects _____

All medications should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Physician please check if applicable:

- ☐ If morning dose is not given at home, nurse may administer **morning dose of** _____ after verbal or written notification from parent.
- ☐ Medication **should** be taken on field trips.
- ☐ Medication **should** be given during school sponsored after school and/or weekend activities/sports

Physician's Signature _____ **Date** _____

Physician's Name (Please Print) _____ **Phone** _____

I give permission for the above medication to be administered to my child as ordered by my health care provider and for the school nurse to share information with physician regarding this medication.

Parent's Signature _____ **Date** _____

Permission for Students to Carry Medication

A student may self-carry if:

- The student is in grades 6-12. An exception to this rule is when the medication is a metered dose inhaler for asthma, an Epi-Pen, diabetic medication or Lactaid in which case younger students may be permitted to carry and self-administer.
- The medication is **not:** a controlled substance, psychotropic, for ADHD, or contains dextromethorphan (DMX) or stimulant decongestants.
- An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.
- Parent assumes responsibility for insuring that his/ her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

_____ _____
Physician's Signature* **Date**

I assume responsibility for ensuring that my child is carrying and taking his/her medication as ordered.

_____ _____
Parent's Signature **Date**

***** A licensed prescriber is required for all medications including all over the counter (OTC) and prescription medications.
***** A **non-parent** licensed prescriber is required for all controlled medication.