OCEAN VIEW SCHOOL DISTRICT
Student Services/Health Services

Questionnaire for Parents of Child with Asthma

Please print:

School Year: _____ **Date:** _____

Student Name: _____ **Birth Date:** _____ **Grade:** _____

Parent Name: _____ **Home #:** _____ **Work #:** _____

Physician Name: _____ **Telephone:** _____

You have notified the school that your child has asthma. The following information will be helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer to the best of your ability and return this form to the school office. Thank you!

Nurse's Name: _____ **Telephone:** _____
School Fax: _____

1. Has your child been diagnosed by a doctor as having asthma? Yes ❑ No ❑
2. Is your child currently under a doctor's care for asthma? Yes ❑ No ❑
   Physician's Name: _____ Telephone: _____
3. Please rate the severity of his/her asthma. (Circle one)

   (Not severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

4. Which of the following causes your child to have breathing difficulty or wheezing (asthma attack)?
   - ❑ Playing on grass
   - ❑ Seasonal pollens: spring/fall
   - ❑ Contact with animal hair
   - ❑ Physical activity
   - ❑ Weather conditions
   - ❑ Food
   - ❑ Other
   - ❑ Drug allergy
   - ❑ Illness/Infection
   - ❑ Emotions

   What kind? _____
   What kind? _____
   What kind? _____
   Specify: _____

5. How many minutes or hours does an asthma attack usually last? _____
6. Does your child have any restrictions due to asthma? Yes ❑ No ❑
   If yes, were these restrictions recommended by a doctor? Yes ❑ No ❑
   What are these restrictions? _____
7. What helps relieve symptoms during an asthma episode (i.e., rest, medication, positioning, liquids, breathing exercises, etc.)? _____
8. Please list the medications your child takes for asthma?

   _____ Daily ❑ As needed ❑
   _____ Daily ❑ As needed ❑
   _____ Daily ❑ As needed ❑

9. If medications are to be given during school, please request a permission slip from the health office and follow the directions on the form. Your cooperation is greatly appreciated.

Ocean View School District
Asthma Action Plan

Name_____ **DOB**_____ **School**_____ **Grade**___

Triggers (check all that apply):
☐ Respiratory infections ☐ Exercise ☐ Pollen ☐ Dust ☐ Mold ☐ Cold air ☐ Weather changes

☐ Animals ☐ Food (list all): _____ ☐ Other: _____

Health care provider to complete remainder of this page:

Daily Controller Medicine given at home (Please list): _____

Good Control Breathing is good No cough or wheeze Activity easily tolerated Sleeps well at night	**Plan:** ▪ Allow activity as tolerated ▪ Use inhaler if needed before exercise/ PE, as indicated in orders below ▪ Or use inhaler as directed by parent
Acute Asthma Attack **If student has any of these Signs or Symptoms:** Coughing, wheezing Short of breath, especially with activity Complaints of tightness in chest Problems working or playing	**Plan:** ▪ Use inhaler as ordered below ▪ Stay with student / Reassure student ▪ Have student rest in most comfortable position until symptom free ▪ PE limitations: _____
If symptoms don't improve or worsen Child should feel better within 20-60 minutes. If getting worse, proceed to Severe/Prolonged Asthma Attack	**Plan:** ▪ Notify school nurse and parents ▪ Repeat inhaler as ordered below
Severe/Prolonged Asthma Attack **If student has any of these Signs or Symptoms:** Difficulty breathing, coughing, wheezing **with no relief from inhaler** Difficulty walking/talking due to asthma symptoms Turning blue, especially around lips or fingernails Neck/chest pulls in with breathing	**Plan:** ▪ Take inhaler as ordered below ▪ **CALL 911** ▪ Notify school nurse and parent

Inhaler (Brand) _____ Side Effects: _____ Other Instructions: (i.e.: before PE)_____ *Inhaler should be brought on all field trips or sporting events*	Dose_____ Route_____ Maximum doses per day:	Amount of time between doses_____ **If no relief**, repeat in _____minutes X_____.

Authorized Health Care Provider Signature:_____

Authorized Health Care Provider (printed):_____
Telephone:_____ Date:_____

Parent /Guardian Signature:_____ ***Date:***_____

Reviewed by School Nurse:_____ **Date:**_____

Office Stamp:

Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____

School/District: _____ Teachers Name: _____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____Maximum number of doses

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____Date: _____

This request is valid for a maximum of one year.

Revised 10-3-2018 pk

Orange County Department of Education
Community and Student Support Services

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

Name of Student: _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter,** may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school.

This request is valid for a maximum of one year.

Revised 10-3-2018 pk