



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,

Angela C Radonski, BSN, RN
Nurse Administrator



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 as 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
<input type="checkbox"/> Albuterol Inhaler <input type="checkbox"/> With Spacer	<input type="checkbox"/> 2 (or _____) puffs by mouth 5-20 minutes prior to exercise, as needed (<i>may repeat with 2</i>) <input type="checkbox"/> 2 (or _____) puffs by mouth every 3-4 hours as needed for symptoms. <input type="checkbox"/> If no relief after treatment, call 911 and notify appropriate staff. <input type="checkbox"/> Other:
<input type="checkbox"/> Albuterol via Nebulizer <input type="checkbox"/> Levalbuterol via Nebulizer <input type="checkbox"/> mouthpiece <input type="checkbox"/> mask	<input type="checkbox"/> 1 unit dose every _____ hours as needed for symptoms <input type="checkbox"/> May repeat and call 911 <input type="checkbox"/> Other:
<input type="checkbox"/> EpiPen <input type="checkbox"/> 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 (<i>for clarification on orders</i>)	Fax
Health Care Provider's Printed Name or Stamp	Date	

THIS AUTHORIZATION IS GOOD FOR THE CURRENT 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: <i>Home:</i> _____ <i>Cell:</i> _____ <i>Work:</i> _____ <i>Other:</i> _____	

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

School Nurse Signature: _____	Date: _____
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THANK YOU FOR YOUR ASSISTANCE. PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE.



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
			<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>		<input type="checkbox"/>

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: _____