Farmington PUBLIC SCHOOLS

ASTHMA QUESTIONNAIRE FOR PARENT / GUARDIAN

Student's Name _____ School Year _____/_____

School _____ Teacher/ Homeroom _____

You have indicated on your student's enrollment forms, emergency card and/or health history that your student has asthma. Please complete this questionnaire to share details with the school.

1. Has a doctor diagnosed your student with asthma? ❑ Yes -or- ❑ No
2. Has your student had symptoms of asthma in the last 12 months? ❑ Yes -or- ❑ 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 student currently take medication for asthma? ❑ Yes -or- ❑ No
   If yes, please list all medications _____
4. Please check which of the following is a trigger for your student's asthma
   ❑ animal dander
   ❑ cold air
   ❑ dust
   ❑ weather changes
   ❑ foods (list):
   _____
   _____
   ❑ molds
   ❑ perfumes/oils
   ❑ pollen
   ❑ exercise
   ❑ other:
   _____
   _____
   ❑ respiratory infections
   ❑ strong odors/fumes
   ❑ tobacco smoke
   ❑ cockroach allergen
5. Does asthma prevent your student from participating in school activities? ❑ Yes -or- ❑ No
   If yes, please explain. _____
6. Does your student need medication at school for treatment of asthma? ❑ Yes -or- ❑ No

If your student needs medical attention or medication for Asthma while at school, your student's medical provider must complete and sign an ASTHMA ACTION PLAN. Keep in mind that medications kept at school must have a pharmacy label and the details must match the student and the details on the Action Plan.

7. Is there anything else we need to know about your student's medical condition?
   ❑ Yes -or- ❑ No If yes, please Explain: _____
   _____

Parent/Guardian Signature _____ Date _____

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ASTHMA ACTION PLAN

Attach child's photo

Student's Name_____

School Year _____/_____ Teacher/ Homeroom _____

School _____

Student is allergic to:_____

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

EMERGENCY CONTACTS		
NAME	**PHONE NUMBER**	**RELATIONSHIP**

GO ZONE!	**Use the daily controller medications (typically given at home)**		
You have ***all*** of these: • Breathing is good • No cough or wheeze • Slept through the night • Can work & play	**MEDICINE**	**HOW MUCH**	**HOW OFTEN/WHEN**

CAUTION ZONE!	**In addition to the medications above, add these rescue medications**		
You have ***any*** of these: • Signs of a cold • Exposure to known trigger • Cough • Mild wheeze • Tight chest • Coughing at night	**MEDICINE**	**HOW MUCH**	**HOW OFTEN/WHEN**
	School staff notify parent/ guardian of use at school. Parent/ guardian to notify your asthma care medical provider.		

DANGER ZONE!	**Use the daily controller medications (typically maintenance medications given at home)**		
Your asthma is getting worse fast: • Medication is not helping • Breathing is hard & fast • Nostrils open wide • Trouble speaking • Ribs showing	**MEDICINE**	**HOW MUCH**	**HOW OFTEN/WHEN**
	GET HELP FROM A DOCTOR NOW! IT"S IMPORTANT! DO NOT WAIT! You will need to be seen by a doctor, if you cannot see your doctor or get to an urgent care or emergency room quickly, then call 911! **FOR SCHOOL STAFF - Call 911 as soon as you are in the DANGER ZONE.**		

Student's Name _____ School Year _____/_____

OPTION TO SELF CARRY / SELF ADMINISTER

***Check and/or initial any below that apply to this student*

Students may self-carry/self-administer medications (if in Grades 6-12) only if authorized by the medical provider AND the parent/guardian.

This student is both capable and responsible for self-administering this medication according to school policy

❑ No -or- ❑ Yes - Supervised -or- ❑ Yes - Unsupervised

Medical Provider Initials _____

This student is authorized to self-carry this medication:

❑ No -or- ❑ Yes

Parent/Guardian Initials _____

❑ Please indicate if you have provided additional information as an attachment.

I am in agreement and authorize the medication/plan as stated in this two page plan (see page 1). I certify that this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Medical Provider Signature_____Date_____

Print Provider Name_____Phone_____

Address_____City/State_____Zip Code_____

Parent/Guardian Signature_____Date_____

Any additional Information to provide to First Responders from Parent/Guardian or Medical Provider:

NOTE: This form also serves as the FPS Authorization for Medication Plan for Asthma.