SUNNYVALE SCHOOL DISTRICT

Authorized Healthcare Provider Authorization and Parent Consent For Management of Asthma at School and School Sponsored Activities

Pupil **DOB** **School** **Grade**

Authorized Healthcare Provider's Authorization: Please initial and check all boxes that apply

1. Control Medication to be taken at school:
Medication name: _____
Dose: _____
How to take: _____
Time: _____
Medication name: _____
Dose: _____
How to take: _____
Time: _____

2. Quick relief medication when symptoms occur at school:
Medication name: _____
Dose: _____
How to take: _____
Time: _____
Medication name: _____
Dose: _____
How to take: _____
Time: _____

3. Preventive Medication before exertion or exercises
Medication name: _____
Dose: _____
How to take: _____
Time: _____
- ☐ Spacer used
- ☐ Spacer with mask used
- ☐ open mouth technique

4. Possible Medication side effects at school: _____

5. **Physician Asthma Action Plan Attached :** ☐ Yes ☐ No
6. ☐ Mechanical Nebulizer: ☐ Mask ☐ Mouthpiece
☐ Spacer ☐ Open mouth technique
Nebulizer Medication: _____
Dose: _____
Time: _____

7. ☐ Monitoring at school by symptoms only
Symptoms: _____
☐ **By peak flow meter and symptoms**
Best peak flow is: _____
Peak flow meter used: _____
Monitoring times: _____

8. Factors that cause an asthma episode:

☐ Exercise	☐ Respiratory infection
☐ Cold weather	☐ Strong odors or fumes
☐ Chalk dust	☐ Cockroaches
☐ Dust mite	☐ Perfume
☐ Air pollution	☐ Molds
☐ Paint	☐ Animal fur or feathers
☐ Smoke	☐ Change of weather
☐ Flowers	☐ Pollens _____
☐ Bushes	☐ Food _____
☐ Trees	☐ Other _____

9. ☐ **Allergies:**

Other Needs (Specify on physician stationary or prescription pad and attach) _____

Authorized Health Care Provider Authorization For Asthma Management In School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Authorized Healthcare Provider Name _____ **Signature** _____ **Date** _____
Phone _____ **Address** _____ **City** _____ **Zip** _____

☐ I have instructed the above named pupil in the proper way to use his/her medications. It is my professional opinion that they should be allowed to carry and use that medication by him/herself. ____ Authorized Healthcare Provider Initial

☐ I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).

Parent Consent for Authorization for Asthma Management In School

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for healthcare in school be administered to my (our) child in accordance with state laws and regulations.
I (we) will:
1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending authorized healthcare provider.
3. Notify the school nurse immediately and provide new consent for any changes in authorized healthcare provider's orders,

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.
I (we) understand that I (we) will be provided a copy of my child's completed Individual School Healthcare Plan. (ISHP)
Parent/Guardian Signature _____ **Date** _____
_____ **Date** _____

Reviewed by School Nurse (Signature) _____ **(Date)** _____
Reviewed by Principal (Signature) _____ **(Date)** _____