

Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

Student	Student Name: _____	Birth Date: _____								
Released By	I authorize: This/these entity(ies) (name/address of recipient(s)): _____ Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student									
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Purpose	For the purpose(s) of: ☐ This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. ☐ Other purposes (specify each purpose): _____ _____									
Information to be Disclosed	Description or nature of information to be used and/or disclosed: (check all that apply) <div style="display: flex; justify-content: space-between;"> <div> ☐ Assessment/Intake Summary ☐ Service/Treatment Plan ☐ Safety/Crisis Plan </div> <div> ☐ Psychiatric Reports ☐ Progress Report ☐ Other records(specify): _____ </div> </div> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> Mental Health ☐ Yes ☐ No ☐ N/A </td><td style="padding: 5px;"> My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. </td></tr> <tr> <td style="padding: 5px;"> Substance Use ☐ Yes ☐ No ☐ N/A </td><td style="padding: 5px;"> My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. </td></tr> </table>		Mental Health ☐ Yes ☐ No ☐ N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	Substance Use ☐ Yes ☐ No ☐ N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.				
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Expiration	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period: Date: _____									
Signatures	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> _____ Signature of student </div> <div style="width: 45%;"> _____ Date </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 33%;"> _____ Signature of legal/personal representative </div> <div style="width: 33%;"> _____ Relationship to student </div> <div style="width: 33%;"> _____ Date </div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; padding: 5px;">Update of Authorization</td><td style="width: 40%; padding: 5px;">Signature 1: _____</td><td style="width: 15%; padding: 5px;">Date: _____</td><td style="width: 20%;"></td></tr> <tr> <td></td><td style="padding: 5px;">Signature 2: _____</td><td style="padding: 5px;">Date: _____</td><td></td></tr> </table>		Update of Authorization	Signature 1: _____	Date: _____			Signature 2: _____	Date: _____	
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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
☐ Albuterol Inhaler ☐ With Spacer	☐ 2 (or____) puffs by mouth 5-20 minutes prior to exercise, as needed (<i>may repeat with 2</i>) ☐ 2 (or____) puffs by mouth every 3-4 hours as needed for symptoms ☐ If no relief after treatment, call 911 and notify appropriate staff ☐ Other:
☐ Combination Inhaler ☐ Budesonide-formoterol ☐ Mometasone-formoterol ☐ Budesonide-albuterol ☐ Other:	☐ 1 (or____) puffs by mouth 5-20 minutes prior to exercise, as needed (<i>may repeat with 2</i>) ☐ 1 (or____) puffs by mouth every 3-4 hours as needed for symptoms ☐ If no relief after treatment, call 911 and notify appropriate staff ☐ Other:
Nebulizer Treatment Type ☐ Albuterol ☐ Levalbuterol ☐ Other:	☐ 1 unit dose every ____ hours as needed for symptoms ☐ May repeat and call 911 ☐ Other:

- ☐ Student has been instructed in use of device needed to administer medication
☐ Student has demonstrated the skill 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.
☐ Other: _____

Health Care Providers 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:	
<p>I request that the school nurse, principal, or designated staff member be permitted to administer to my child (<i>name of child</i>) _____ or allow my child to carry and self-administer as indicated above, the medication prescribed by (<i>name of provider</i>) _____ 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 legal guardian of the child named.</p>	
Parent/Guardian Signature: _____	Date: _____
Parent Contacts: <i>Home:</i> _____	<i>Cell:</i> _____ <i>Work:</i> _____ <i>Other:</i> _____

STUDENT DEMONSTRATES SKILL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE.	
School Nurse Signature: _____	Date: _____

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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
			☐		☐
			☐		☐
			☐		☐
			☐		☐
			☐		☐
			☐		☐

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: _____



AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Diagnosis: _____

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day to be Taken</u>
---------------------------	---------------	----------------------------------	--------------------------------

If given PRN, specify the length of time between doses.

Student is capable to self-administer medication: ☐ Yes ☐ No

If a health professional and a student's parent request that a student be permitted to carry his or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse.

Possible side effect of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (do not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Health Care Provider Signature	Date
--------------------------------	------

Health Care Provider (Type or Print)	Telephone Number
--------------------------------------	------------------

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Parent/Guardian Signature	Date
---------------------------	------

Parent/Guardian (Type or Print)	Telephone Number
---------------------------------	------------------